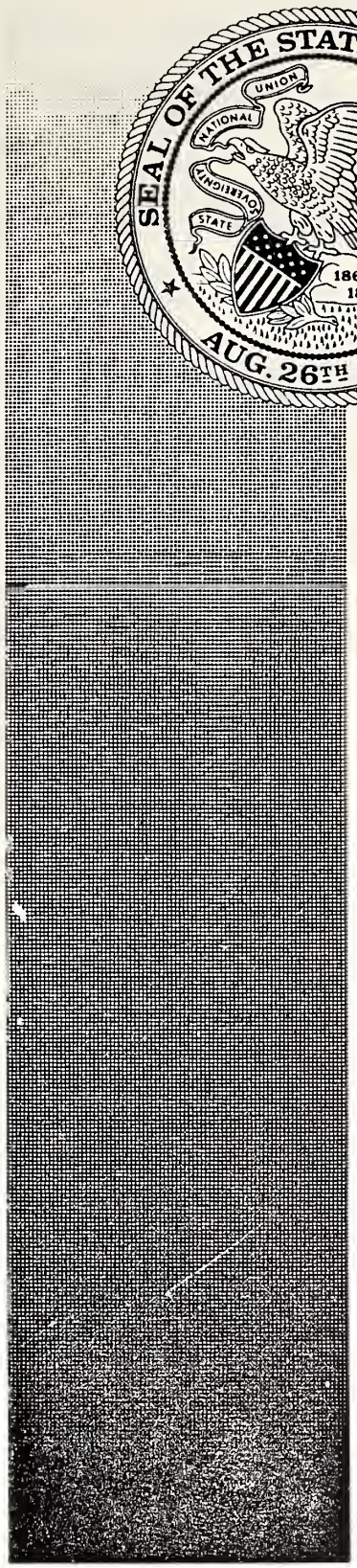

1992

Illinois Register

Rules of Governmental Agencies

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published by
George H. Ryan
Secretary of State

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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category. Rulemaking activity consists of proposed or adopted new rules or amendments to or repealers of existing rules, including those by emergency or peremptory action.

The *Register* also contains Executive Orders and Proclamations issued by the Governor, notices of public information required by State statute, and activities (meeting agendas, Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State agencies. In addition, the *Register* contains a Cumulative Index listing alphabetically by agency the Parts (sets of rules) on which rulemaking activity has occurred in the current *Register* volume and a Sections Affected Index listing, by Title of the *Illinois Administrative Code*, each Section (including supplementary material) of a Part on which rulemaking activity has occurred in the current volume. Both indices are action coded and are designed to aid the public in monitoring rules.

The *Register* will serve as the update to the *Illinois Administrative Code*, a compilation of the rules of State agencies. The most recent edition of the *Code* along with the *Register* comprise the most current accounting of the State agencies' rules.

The *Illinois Register* is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act (Ill. Rev. Stat. 1991, ch. 127, pars. 1001 et seq., as amended).

REGISTER PUBLICATION SCHEDULE 1992

Material Rec'd after 4:30 p.m. on:	And before 4:30 p.m. on:	Will be in Issue #:	Published on:	Material Rec'd after 4:30 p.m. on:	And before 4:30 p.m. on:	Will be in Issue #:	Published on:
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Please note: When the Register deadline falls on a State holiday, the deadline becomes 4:30 p.m. on Monday *(the day before)*.

Printed by authority of the
State of Illinois
February 1992 – 890 – GA-1048

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: ABANDONED MINED LANDS RECLAMATION

2) Code Citation: 62 Ill. Adm. Code 2501

3)

Section Number	Proposed Action
2501.37	New Section

4) Statutory Authority:

Ill. Rev. Stat. 1989, ch. 96½, par 8003.01

5) A complete Description of the Subjects and Issues Involved:

P.A. 87-39 which became law on September 9, 1991 added anew Section 2.12 to the Abandoned Mined Lands and Water Reclamation Act. The statute requires the Abandoned Mined Lands Reclamation Council to file a Notice of Reclamation following reclamation activities, in the office of the Recorder in the county in which the reclaimed land lies. The proposed rule will implement P.A. 87-379.

6) Will the proposed amendments replace an emergency rule currently in effect?

Yes.

7) Does this rulemaking contain an automatic repeal date?

No.

8) Do the proposed amendments contain incorporations by reference?

No.

9) Are there any other proposed amendments on this Part?

No.

10) Statement of Statewide Policy Objectives:

Not Applicable. The rulemaking does not create or expand a State mandate on units of local government, school districts, or community college districts.

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF PROPOSED AMENDMENTS

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Interested persons may submit written comments within 45 days of the date of publication of this notice to:

Kevin H. Kahl, Legal Counsel
Abandoned Mined Lands Reclamation Council
928 South Spring Street
Springfield, IL 62704
217/782-0588

12) Initial Regulatory Flexibility Analysis:

Not Applicable. Does not regulate small businesses.

13) The full text of the Proposed Amendments is identical to the text of the Emergency Amendments appearing on page 2899 of this Issue of the Illinois Register.

DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED RULES

1) Heading of the Part: Americans With Disabilities Act Grievance Procedure

2) Code Citation: 4 Ill. Adm. Code 500

3)

Section Numbers:	Proposed Action:
500.1	New Section
500.2	New Section
500.3	New Section
500.4	New Section
500.5	New Section
500.6	New Section
500.7	New Section

4) Statutory Authority: Implementing Title II, Subtitle A of the Americans With Disabilities Act of 1990 (42 U.S.C. 12131-12134), as specified in Title II regulations (28 CFR 35.107), and authorized by Sections 4-101 of the Illinois Alcoholism and Other Drug Dependency Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par 6354-1).

5) A Complete Description of the Subjects and Issues Involved:

As required by the Americans with Disabilities Act of 1990, these proposed rules establish a procedure whereby qualified persons with disabilities may resolve allegations of discrimination on the basis of disability.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed rule contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These rules will not create or enlarge a State mandate.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Written comments may be submitted within 45 days of the publication of this notice to:

Jane Mortell
Associate General Counsel
Illinois Department of Alcoholism and Substance Abuse
100 West Randolph Street
Suite 5-600
Chicago, Illinois 60601
(312) 814-6387 (Voice)

DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED RULES

(312) 419-8432 (TDD)

12) Initial Regulatory Flexibility Analysis:

A) Date rules were submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: January 21, 1992.

B) Types of small businesses affected: The grievance procedure set forth in this Part will not affect small businesses.

C) Reporting, bookkeeping or other procedures required for compliance: Small business will not be required to undertake any reporting or bookkeeping activities pursuant to this Part.

D) Types of professional skills necessary for compliance: No professional skills are required of small business pursuant to this Part.

The full text of the Proposed Rules begins on the next page:

DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED RULES

TITLE 4: GRIEVANCE PROCEDURES
CHAPTER XVII: DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

PART 500

AMERICANS WITH DISABILITIES ACT GRIEVANCE PROCEDURE

Section
500.1 Purposes
500.2 Definitions
500.3 Procedure
500.4 Designated Coordinator Level
500.5 Final Level
500.6 Accessibility
500.7 Case-by-Case Resolution

AUTHORITY: Implementing Title II, Subtitle A of the Americans With Disabilities Act of 1990 (42 U.S.C. 12131-12134), as specified in Title II regulations (28 CFR 35.107), and authorized by Section 4-101 of the Illinois Alcoholism and Other Drug Dependency Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 6354-1).

SOURCE: Adopted at 16 Ill. Reg. _____, effective _____.

Section 500.1 Purposes

a) This Part establishes an Americans With Disabilities Act Grievance Procedure (Procedure) pursuant to the Americans With Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) (ADA), and specifically Section 35.107 of the Title II regulations (28 CFR 35.107) requiring that a grievance procedure be established to resolve grievances asserted by qualified individuals with disabilities. Should any individual desire to review the ADA or its regulations to understand the rights, privileges and remedies afforded by it, please contact the Designated Coordinator.

b) In general, the ADA requires that each program, service, and activity offered by the Department of Alcoholism and Substance Abuse (Department), when viewed in its entirety, be readily accessible to and usable by qualified individuals with disabilities.

c) It is the intent of the Department to foster open communication with all individuals requesting ready access to programs, services and activities. The Department encourages staff to respond to requests for modifications before they become grievances.

Section 500.2 Definitions

DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED RULES

"Complainant" is an individual with a disability who files a grievance form provided by the Department in accordance with this Part.

"Designated Coordinators" are the persons appointed by the Department Director to coordinate the Department's efforts to comply with and carry out its responsibilities under Title II of the ADA, including investigation of grievances filed by complainants. The Designated Coordinators for the Department can be contacted at the Illinois Department of Alcoholism and Substance Abuse, 100 West Randolph Street, Suite 5-600, Chicago, Illinois 60601 (312) 814-3840 (voice) or (312) 419-8432 (TDD).

"Disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or being regarded as having such an impairment.

"Grievance" is any complaint under the ADA by an individual with a disability who meets the essential eligibility requirements for participation in or receipt of the benefits of a program, activity or service offered by the Department, and who believes he or she has been excluded from participation in or denied the benefits of any program, service or activity of the Department, or has been subject to discrimination by the Department, on the basis of his or her disability.

"Qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the Department.

Section 500.3 Procedure

a) Grievances shall be submitted in accordance with the procedures established in Sections 500.4 and 500.5 of the Part, in the form and manner described, and within specified time limits. Time limits established in this procedure are in calendar days, unless otherwise stated, and may be extended by mutual agreement in writing by the complainant and the reviewer at the Designated Coordinator and Final Levels.

b) A complainant's failure to submit a grievance, or to submit or appeal it to the next level of procedure, within the specified time limits shall mean that the complainant has withdrawn the grievance or has accepted the last response given in the grievance procedure as the Department's final response.

c) The Department shall, upon being informed of an individual's desire to file a formal grievance, instruct the individual how to receive a copy of this procedure and the grievance form.

Section 500.4 Designated Coordinator Level

a) If an individual desires to file a formal written grievance, the individual shall promptly, but no later than 180 days after the alleged discrimination, submit the grievance to a Designated Coordinator in writing on the grievance form prescribed for that purpose. The grievance form shall be completed in full in order to receive proper consideration by the Designated Coordinator, and shall include:

1) the complainant's name and, if applicable, address and telephone number;

2) the best means and time for contacting the complainant;

3) the program, activity or service which was denied complainant or in which alleged discrimination occurred;

4) the date and nature of the alleged denial or discrimination;

5) the signature of the complainant, or his/her authorized designee.

b) Upon request, assistance shall be provided by the Department to complete the grievance form.

c) A Designated Coordinator or designee shall investigate the grievance and shall make reasonable efforts to resolve it. The Designated Coordinator shall provide a written response to the complainant and to the Director of the Department within ten (10) business days after receipt of the grievance form.

Section 500.5 Final Level

a) If the grievance is not resolved to the satisfaction of the complainant at the Designated Coordinator Level, the complainant may submit a copy of the grievance form and Designated Coordinator's response to the Director of the Department for final review. The complainant shall submit these documents to the Director, or his or her designee, together with a short written statement explaining the reason(s) for dissatisfaction with the Designated Coordinator's written response, within five (5) business days after receipt by the complainant of the Designated Coordinator's response.

b) The complainant shall be afforded an opportunity to appear before the Director. The complainant shall have a right to appoint a representative to appear on his or her behalf. The Director shall review the Designated Coordinator's written response and may conduct interviews and seek advice as the Director deems appropriate.

c) The Director shall approve, disapprove or modify the recommendation of the Designated Coordinator, shall render a decision thereon in writing within thirty (30) days, shall state the basis therefore, and shall cause a copy of the decision to be served on the parties. The Director's decision shall be final. If the Director disapproves or modifies the Designated Coordinator's recommendations, the Director shall include written reasons for such disapproval or modification.

d) The grievance form, the Designated Coordinator's response, the statement of reasons for dissatisfaction, and the decision of the Director shall be maintained in accordance with the State Records Act (Ill. Rev. Stat. 1989, ch. 116, par. 43.3 et seq.) or as otherwise required by law.

Section 500.6 Accessibility

The Department shall ensure that all stages of the grievance procedure are readily accessible to and usable by individuals with disabilities.

Section 500.7 Case-by-Case Resolution

Each grievance involves a unique set of factors which include, but are not limited to: the specific nature of the disability; the essential eligibility requirements, the benefits to be derived, and the nature of the service, program or activity at issue; the health and safety of others; and, whether or not an accommodation would constitute a fundamental alteration to the program, service or activity or undue hardship on the Department. Accordingly, termination of a grievance at any level, whether through the granting of relief or otherwise, shall not constitute a precedent on which any other complainants should rely.

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED REPEALER

1) HEADING OF THE PART: Pigeon Shooting Permits

2) CODE CITATION: 17 Ill. Adm. Code 970

3)

SECTION NUMBERS:	PROPOSED ACTION:
970.10	Repeal
970.20	Repeal
970.30	Repeal
970.40	Repeal
970.50	Repeal
970.60	Repeal

4) STATUTORY AUTHORITY: Implementing and authorized by Sections 111.1, 111.2 and 111.3 of "AN ACT to regulate the shooting of domestic pigeons, fowl or other birds for sporting purposes or as a test of skill in marksmanship and to repeal an Act herein named" (Ill. Rev. Stat. 1989, ch. 8, pars. 111.1, 111.2 and 111.3).

5) A COMPLETE DESCRIPTION OF THE SUBJECTS AND ISSUES INVOLVED: This Part is being repealed pursuant to Public Act 87-798, effective December 16, 1991, which repealed the Bird Shooting Act (Ill. Rev. Stat. 1989, ch. 8, pars. 111.1, 111.2 and 111.3)

6) WILL THIS PROPOSED REPEALER REPLACE AN EMERGENCY RULE CURRENTLY IN EFFECT? No

7) DOES THIS RULEMAKING CONTAIN AN AUTOMATIC REPEAL DATE? No

8) DOES THIS PROPOSED REPEALER CONTAIN INCORPORATIONS BY REFERENCE? No

9) ARE THERE ANY OTHER PROPOSED AMENDMENTS PENDING ON THIS PART? No

10) STATEMENT OF STATEWIDE POLICY OBJECTIVES: This rule has no impact on local governments.

11) TIME, PLACE AND MANNER IN WHICH INTERESTED PERSONS MAY COMMENT ON THIS PROPOSED REPEALER: Comments on the proposed rule may be submitted in writing for a period of 30 days following publication of this notice to:

Don Woods
Department of Conservation
524 S. Second Street, Room 485
Springfield, IL 62701-1787

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED REPEALER

12) INITIAL REGULATORY FLEXIBILITY ANALYSIS: This rule has no impact on small businesses or municipalities

THE FULL TEXT OF THE PROPOSED REPEALER BEGINS ON THE NEXT PAGE:

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED REPEALER

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF CONSERVATION
SUBCHAPTER b: FISH AND WILDLIFE

PART 970
PIGEON SHOOTING PERMITS

Section
970.10 Definitions
970.20 Pigeon Shooting Permits
970.30 Pigeon Shoot Certificate of Registration
970.40 Pigeon Shoot Regulations
970.50 Exemptions
970.60 Penalties, Future Rights/Appeal Procedures

AUTHORITY: Implementing and authorized by Sections 111.1, 111.2 and 111.3 of "AN ACT to regulate the shooting of domestic pigeons, fowl or other birds for sporting purposes or as a test of skill in marksmanship and to repeal an Act herein named" (Ill. Rev. Stat. 1989, ch. 8, pars. 111.1, 111.2 and 111.3).

SOURCE: Adopted at 13 Ill. Reg. 16447, effective October 4, 1989, repealed at 16 Ill. Reg. _____, effective _____.

Section 970.10 Definitions

Department - Department of Conservation

Pigeon Shoot - The shooting of pigeons for sporting purposes or as a test of skill in marksmanship

Section 970.20 Pigeon Shooting Permits

a) Pigeon Shooting Permits are available from the Department by contacting:

Illinois Department of Conservation
Division of Wildlife Resources
524 S. Second Street
Lincoln Tower Plaza
Springfield, IL 62701-1787
Telephone: 217-782-6384

b) Persons requesting Pigeon Shooting Permits must supply the following information:

1) name of the person or organization sponsoring the Pigeon Shoot;

2) date(s) the Pigeon Shoot is to be conducted;

3) the location where the Pigeon Shoot will be conducted in distance and direction from the nearest town; and

4) the name of the property owner(s) on whose property the Pigeon Shoot will be conducted.

c) Persons requesting Pigeon Shooting Permits must contact the Department at least four weeks in advance of the date of the Pigeon Shoot.

d) Pigeon Shooting Permits shall be effective only for use on the property described in the permit.

Section 970.30 Pigeon Shoot Certificate of Registration

a) Each Pigeon Shoot contestant must complete an application for a Pigeon Shoot Certificate of Registration and must also complete and have in possession while participating in the Pigeon Shoot a Pigeon Shoot Certificate of Registration card.

b) Applications for Pigeon Shoot Certificate of Registration cards must contain the following information:

1) date;

2) name;

3) address;

4) age, height, weight;

5) signature; and

6) signature of a Department representative or of the person sponsoring the Pigeon Shoot.

c) Pigeon Shoot Certificate of Registration cards shall be issued by the Department or the sponsor of the Pigeon Shoot and must contain the same information as the application for the card except the signature of a Department representative or the person sponsoring the Pigeon Shoot is not required.

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED REPEALER

d) Pigeon Shoot Certificate of Registration cards are valid for any Pigeon Shoot in Illinois for a period of one year from the date of issuance.

Section 970.40 Pigeon Shoot Regulations

a) A reasonable effort must be made to retrieve crippled pigeons immediately after every contestant has finished shooting. All crippled pigeons must be immediately euthanized.

b) The rules of the sponsor of the Pigeon Shoot which govern its conduct must be conspicuously posted at the location of the Pigeon Shoot.

c) The Department reserves the right to have a representative in attendance at Pigeon Shoots.

Section 970.50 Exemptions

The shooting of pigeons during sporting dog training or sporting dog field trials, to control a nuisance pigeon population, or for hunting purposes is exempt from the provisions of this Part.

Section 970.60 Penalties, Future Rights/Appeal Procedures

a) In addition to any penalties prescribed by Section 111.3 of "AN ACT to regulate the shooting of domestic pigeons, fowl or other birds for sporting purposes or as a test of skill in marksmanship and to repeal an Act herein named" (Ill. Rev. Stat. 1989, ch. 8, par. 113.3) (The Act), the Department will revoke and refuse to issue further pigeon shooting permits for violation of Sections 111.1 and 111.2 of the Act or this Part.

b) Persons whose Pigeon Shooting Permits have been revoked or who have been denied future permits may contest these actions according to the process delineated in 17 Ill. Adm. Code 2530.

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

1) Heading of the Part: Fees for Processing Requests for Conviction Information

2) Code Citation: 20 Ill. Adm. Code 1570

3) Section Numbers: Proposed Action

1570.10	New Section
1570.20	New Section
1570.30	New Section
1570.40	New Section
1570.50	New Section
1570.60	New Section

4) Statutory Authority: Ill. Rev. Stat., 1989, ch. 38, par. 1601 et seq.

5) A complete description of the subjects and issues involved: Pursuant to the Illinois Uniform Conviction Information Act (Ill. Rev. Stat., 1989, ch. 38, par. 1601 et seq.), these rules establish the form and manner for a criminal justice agency other than the Department of State Police to assist a person who requests conviction information and the maximum fee that may be charged and assessed for processing such a request.

6) Will this proposed rulemaking replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed rule contain incorporations by reference?

No

9) Are there any other amendments pending on this part? No

10) Statement of Statewide Policy Objectives: These rules are being proposed to establish uniform procedures by which criminal justice agencies other than the Department of State Police agencies may assist a person who requests conviction information, pursuant to the Illinois Uniform Conviction Information Act, and to inform such agencies of the criteria that will be used to determine the maximum fee they may charge for processing a request. In addition, these rules

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

are being formulated, consistent with the Act, to encourage the use of fingerprint-based requests for conviction information in order to increase the accuracy and completeness of the information provided.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Any interested person may submit written comments or arguments concerning this proposed rule. Written submissions shall be filed with:

Mr. Paul Fields
General Counsel
Illinois Criminal Justice Information Authority
120 S. Riverside Plaza
Chicago, IL. 60606-3997

12) Initial Regulatory Flexibility Analysis:

These proposed rules do not affect small businesses.

The full text of the Proposed Rules begins on the next page:

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
CHAPTER III: ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY

PART 1570
FEES FOR PROCESSING REQUESTS
FOR CONVICTION INFORMATION

Section
1570.10 Purpose and Authorization
1570.20 Definitions
1570.30 Form and Manner for Assisting in the Processing of Conviction Information
1570.40 Cost Criteria for the Fee to be Charged
1570.50 Fee Determination
1570.60 Notification of Fee Amount

AUTHORITY: Implementing and authorized by the Illinois Uniform Conviction Information Act (Ill. Rev. Stat., 1989, ch. 38, par. 1601 et seq.).

SOURCE: Adopted at ___ Ill. Reg. _____, effective _____, 1992.

Section 1570.10 Purpose and Authorization

Pursuant to the Illinois Uniform Conviction Information Act (Ill. Rev. Stat., 1989, ch.38, par. 1601 et seq.), the Illinois Criminal Justice Information Authority is charged with the responsibility of establishing the form, manner and maximum fee that criminal justice agencies other than the Department of State Police may charge for assisting in the processing of requests for conviction information under the Act. These rules describe the procedure to be followed by a criminal justice agency in processing a request for conviction information under the Act and the method for establishing the fee to be charged for providing such assistance.

Section 1570.20 Definitions

As used in this Part, the terms used herein have the meaning ascribed to them in the Illinois Uniform Conviction Information Act. In addition, unless the context otherwise requires, the following terms have the meaning ascribed to them herein:

"Authority" means the Illinois Criminal Justice Information Authority.

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

"CIR Form" means the Conviction Information Request Form adopted by the Department of State Police (20 Ill. Adm. Code 1215) for requesting information under the Illinois Uniform Conviction Information Act.

"Individual record subject" means the person whose fingerprints are being taken pursuant to a request to obtain conviction information under the Illinois Uniform Conviction Information Act.

Section 1570.30 Form and Manner for Assisting in the Processing of Conviction Information

A) A criminal justice agency that assists in the processing of criminal conviction information requests pursuant to the Illinois Uniform Conviction Information Act shall do so as follows:

1) Provide such assistance, at a minimum, during its regular business hours, Monday through Friday, excluding holidays.

2) Verify the identity of the individual record subject. In making this verification, the agency shall require at least two forms of identification, one of which shall be a photograph identification. Acceptable photographic identification shall be of a nature that cannot easily be forged, such as valid passports or driver's licenses, identification cards issued by the Secretary of State, or military or other photographic identification of a similar reliability.

3) After verification of the identity of the individual record subject, the personnel of the criminal justice agency shall fingerprint the record subject on a CIR Form. It shall be the responsibility of the requester to obtain such form from the Department of State Police.

4) The criminal justice agency shall review the CIR Form to verify that it is accurately completed, as appropriate, by the requester, in conformance with the requirements of the Department of State Police.

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

5) The criminal justice agency may charge the requester a fee pursuant to Section 1570.40.

6) The criminal justice agency shall return the CIR Form to the requester, who shall be responsible for mailing it to the Department of State Police.

B) A local criminal justice agency that does not assist in processing a request for conviction information pursuant to the Illinois Uniform Conviction Information Act shall inform the requester that the conviction information sought can be obtained directly from the Department of State Police at the following address or phone number:

Illinois State Police
Bureau of Identification
260 North Chicago St.
Joliet, Illinois 60431
Telephone number: (815) 740-5160

Section 1570.40 Cost Criteria for the Fee to be Charged

A) The Authority shall establish the maximum fee that may be charged by criminal justice agencies other than the Department of State Police for assisting in the processing of requests for conviction information made pursuant to the Illinois Uniform Conviction Information Act. This fee shall be based on a reasonable estimate of the actual costs to participating criminal justice agencies throughout the state to comply with these rules.

B) In establishing the maximum fee that a criminal justice agency other than the Department of State Police may charge, the Authority shall consider the following criteria:

1) Personnel Costs. The fee charged shall include all personnel costs necessary to assist in the processing of the request forms. Such costs shall include time allocated for:

a) Giving instructions to the requester,

b) Fingerprinting the individual record subject,

c) Reviewing the CIR form,

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

d) Processing the fee, and

e) Supervising and training personnel to comply with these rules.

2) Tangible Costs. The fee charged shall include all expenses incurred by a criminal justice agency other than the Department of State Police which are directly attributable to assisting in the processing of requests for conviction information. Such costs shall include, as may be appropriate, the cost for:

a) Fingerprinting materials and supplies such as ink, rollers, cleaning fluids, and towels, and

b) Telecommunications services.

Section 1570.50 Fee Determination

A) Pursuant to Section 1570.40, the Authority shall establish the maximum fee for each calendar year by December 10th of the preceding year. In establishing this fee amount, the Authority shall consult with representatives of criminal justice agencies, and representatives of municipal, civic, and business groups to:

1) establish a reasonable estimate of the actual costs to participating criminal justice agencies throughout the state to comply with these rules, and

2) determine if there would be an unreasonable negative impact or undue burden placed on requesters of conviction information.

B) Pursuant to the Illinois Uniform Conviction Information Act, nothing herein shall be deemed to prevent a criminal justice agency from waiving or reducing the fee established pursuant to Section 1570.40.

C) For the calendar year 1992, the maximum fee established by the Authority that a criminal justice agency other than the Department of State Police may charge and assess under these rules shall be ten dollars ($10).

CRIMINAL JUSTICE INFORMATION AUTHORITY

NOTICE OF PROPOSED RULES

D) A criminal justice agency may presume that the maximum fee, as determined in this section, shall remain constant from calendar year to calendar year unless specifically notified to the contrary by the Authority pursuant to Section 1570.60.

Section 1570.60 Notification of Fee Amount

A) Within seven working days after the fee has been established for a calendar year, the Authority shall inform the chief executive officer of each criminal justice agency in Illinois of the amount of the fee. However, notice of the fee for a calendar year shall be given no later than December 15th of the preceding calendar year.

B) Other interested agencies, organizations, and the public shall, upon request, also be entitled to be informed of the amount of the fee set by the Authority. Within 7 working days of receipt of such a request, the Executive Director of the Authority shall inform the requester of the fee approved by the Authority.

Requests for notification of the fee amount may be made by calling the Authority at (312)793-8550 between 8:30 a.m. and 5:00 p.m. on working days or by writing to:

Executive Director
Illinois Criminal Justice Information Authority
120 South Riverside Plaza
Chicago, Illinois 60606.
TDD: 312-793-4170

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: NOTICES, INSTRUCTIONS AND REPORTS TO WORKERS; INSPECTIONS

2) Code Citation: 32 Ill. Adm. Code 400

3)

Section Number:	Proposed Action:
400.120	Amendment
400.140	Amendment
400.150	Amendment
400.160	Amendment

4) Statutory Authority: Implementing and authorized by Sections 16 and 29 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1990 Supp,, ch. 111½, pars. 210-16, 210-29), Section 5 of the Personnel Radiation Monitoring Act (Ill. Rev. Stat. 1990 Supp., ch. 111½, par. 230.15).

5) A Complete Description of the Subjects and Issues Involved: The Department is amending this Part to change the cross references to other rules of the Department. Rather than listing the other rules individually by Part number, the Department is proposing to cross reference to 32 Ill. Adm. Code: Chapter II, Subchapters b and d. It is the Department's intent to refer to all Department rules related to radiation protection, low-level radioactive waste and transportation.

6) Will this proposed amendment replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: The requirements imposed by the proposed rulemaking are not expected to require local governments to establish, expand, or modify their activities in such a way as to necessitate additional expenditures from local revenues.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this notice. The Department will consider fully all written comments on this proposed rulemaking submitted during the 45 day comment period. Comments should be submitted to:

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENT

Betsy Salus
Senior Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 785-9881 (voice)
(217) 785-9900 (TDD)

12) Initial Regulatory Flexibility Analysis:

A) Date rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: February 11, 1992

B) Types of small businesses affected: The Department believes that these amendments impose no direct impact on any small businesses that are licensed by the Department to possess, use, distribute, store, treat, or dispose of radioactive materials.

C) Reporting, bookkeeping or other procedures required for compliance: This rulemaking only corrects the references in this section, and consequently does not require licensees to perform reporting, bookkeeping or other procedures for achieving compliance.

D) Types of professional skills necessary for compliance: No particular professional skills are necessary for compliance.

The full text of the Proposed Amendment begins on the next page:

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENTS

TITLE 32: ENERGY
CHAPTER II: DEPARTMENT OF NUCLEAR SAFETY
SUBCHAPTER b: RADIATION PROTECTION

PART 400
NOTICES, INSTRUCTIONS AND REPORTS TO WORKERS; INSPECTIONS

Section
400.10 Purpose and Scope
400.110 Posting of Notices to Workers
400.120 Instructions to Workers
400.130 Notifications and Reports to Individuals
400.140 Presence of Representatives of Licensees or Registrants and Workers During Inspection
400.150 Consultation with Workers During Inspections
400.160 Requests by Workers for Inspections
400.170 Inspections Not Warranted; Informal Review

AUTHORITY: Implementing and authorized by Sections ~~8-8.13~~ 16 and 29 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. ~~1987~~ 1990 Supp., ch. 111½, pars. ~~218.0-218.13~~ 210-16, 210-29), and Section 5 of ~~"AN ACT in relation to personnel monitoring"~~ the Personnel Radiation Monitoring Act (Ill. Rev. Stat. ~~1987~~ 1990 Supp., ch. 111½, par. 230.15).

SOURCE: Adopted at 10 Ill. Reg. 17496, effective September 25, 1986; amended at 11 Ill. Reg. 15629, effective September 11, 1987; amended at 13 Ill. Reg. 13581, effective August 11, 1989; amended at ___ Ill. Reg. _____, effective _____.

Section 400.120 Instructions to Workers

a) All individuals working in, or the performance of whose duties requires access to any portion of a restricted area:

1) shall be kept informed of the storage, transfer, or use of sources of radiation in such portions of the restricted area;

2) shall be instructed in the health protection problems associated with exposure to radiation or radioactive material, in the risks of radiation exposure to the embryo and fetus, in precautions or procedures to minimize exposure, and in the purposes and functions of protective devices employed;

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENTS

3) shall be instructed in, and instructed to observe to the extent within the worker's control, the conditions of the license, the provisions of this Part and 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 401 and 601~~: Chapter II, Subchapters b and d for the protection of personnel from exposures to radiation or radioactive material occurring in such areas;

4) shall be instructed to report promptly to the licensee or registrant any condition which may constitute, lead to, or cause a violation of the Act, the conditions of the license, the provisions of this Part or 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 360, 370, 380, 390, 401, 410 and 601~~: Chapter II, Subchapters b and d or unnecessary exposure to radiation or radioactive material;

5) shall be instructed in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation or radioactive material; and

6) shall be advised as to the radiation exposure reports which workers shall be furnished pursuant to Section 400.130.

b) These instructions shall be of sufficient detail to avoid radiological health protection problems and shall be given directly to each worker either in writing or in an orientation course, with the workers signing a statement that they have received the above information and understand it.

(Source: Amended at ___ Ill. Reg._____, effective _____)

Section 400.140 Presence of Representatives of Licensees or Registrants and Workers During Inspection

a) Pursuant to Section 400.160 and 32 Ill. Adm. Code 310.50, each licensee or registrant shall afford the Department at all reasonable times the opportunity to inspect such materials, machines, activities, facilities, premises, and records as the Department determines are necessary to establish compliance with the requirements of the license and the provisions of 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 360, 370, 380, 390, 400, 401, 410, and 601~~: Chapter II, Subchapters b and d. Reasonable times shall be any time the facility is operational. The inspection may be announced or unannounced. Materials licensees shall be inspected at least as frequently as they would have been inspected by the U.S. Nuclear Regulatory Commission

(U.S. NRC) if the licensees were regulated by the U.S. NRC, but no more frequently than once in a calendar quarter. Radiation machines shall be inspected in accordance with the provisions of Sections 8.11 and 8.13 of the Act. Inspection of licensees and radiation machines may be conducted more frequently than once per calendar quarter if, in the past three years, there has been a condition at the facility which required emergency response; or if the Department has received a complaint, the investigation of which will result in a more frequent inspection; or if the Department has documented a violation of the Act or the above referenced rules of the Department at the facility and additional inspections are necessary to establish that the violation has been abated.

b) During an inspection, Departmental and qualified nondepartment inspectors may consult privately with workers as specified in Section 400.150. The licensee or registrant may accompany Departmental and qualified nondepartment inspectors during other phases of an inspection.

c) If, at the time of inspection, an individual has been authorized by the workers to represent them during inspections, the licensee or registrant shall notify the Departmental or qualified nondepartment inspectors of such authorization and shall give the workers' representative an opportunity to accompany the inspectors during the inspection of physical working conditions.

d) Each workers' representative shall be routinely engaged in work under control of the licensee or registrant and shall have received instructions as specified in Section 400.120.

e) Different representatives of licensees or registrants and workers may accompany the Departmental or qualified nondepartment inspectors during different phases of an inspection if there is no resulting interference with the conduct of the inspection. However, only one workers' representative at a time may accompany the inspectors.

f) With the approval of the licensee or registrant and the workers' representative, an individual who is not routinely engaged in work under control of the licensee or registrant, for example, a consultant to the licensee or registrant or to the workers' representative, shall be afforded the opportunity to accompany Departmental and qualified nondepartment inspectors during the inspection of physical working conditions.

g) Notwithstanding the other provisions of this Section, Departmental inspectors and qualified nondepartment inspectors are authorized to refuse to permit accompaniment by any individual who deliberately interferes with a fair and orderly inspection. With regard to areas containing information classified by an agency of the U.S. Government in the interest of national security, an individual who accompanies an inspector may have access to such information only if authorized to do so. With regard to any area containing proprietary information, i.e., trade secrets and commercial or financial information where such information is privileged or confidential or where disclosure of such information may cause competitive harm, the workers' representative for that area shall be an individual previously authorized by the licensee or registrant to enter that area.

(Source: Amended at ___ Ill. Reg._____, effective _____)

Section 400.150 Consultation with Workers During Inspections

a) Departmental and qualified nondepartment inspectors may consult privately with workers concerning matters of occupational radiation protection and other matters related to the activities of the licensee or registrant which bear upon compliance with the conditions of the license or the provisions of this Part or 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 360, 370, 380, 390, 401, 410 or 601~~: Chapter II, Subchapters b and d.

b) During the course of an inspection, or at any other time, any worker may bring privately to the attention of the Department, its inspectors or qualified nondepartment inspectors, either orally or in writing, any past or present condition which the worker has reason to believe may have contributed to or caused any violation of the Act, the provisions of this Part or 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 360, 370, 380, 390, 401, 410, and 601~~: Chapter II, Subchapters b and d or license condition, or any unnecessary exposure of an individual to sources of radiation under the licensee's or registrant's control. Any such notice in writing shall comply with the requirements of Section 400.160(a). If a worker seeks an opportunity to speak to an inspector during an inspection, the licensee or registrant shall permit the worker such opportunity.

AGENCY NOTE: The provisions of subsection (b) shall not be interpreted as authorization to disregard instructions pursuant to Section 400.120.

(Source: Amended at ___ Ill. Reg._____, effective _____)

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENTS

Section 400.160 Requests by Workers for Inspections

a) Any worker or representative of workers believing that a violation of the Act, the provisions of this Part or 32 Ill. Adm. Code ~~310, 320, 330, 331, 340, 341, 350, 351, 360, 370, 380, 390, 401, 410 and 601~~: Chapter II, Subchapters b and d, or license conditions exists or has occurred, or that an unnecessary exposure to radiation or radioactive material has occurred in work under a license or registration with regard to radiological working conditions in which the worker is engaged may request an inspection by giving notice of the alleged violation to the Department. Any such notice shall be in writing, shall set forth the circumstances describing the perceived violation or condition, and shall be signed by the worker or representative of the workers. A copy shall be provided to the licensee or registrant by the Department no later than at the time of inspection except that, upon the request of the worker giving such notice, his name and the name of individuals referred to therein shall not appear in such copy or on any record published, released, or made available by the Department, except for good cause shown, such as when necessary in the course of enforcement actions.

b) If conditions stated on the face of the complaint indicate there is or has been a violation or the possibility of a violation, the Department shall conduct an inspection as soon as practicable to determine if such alleged violation exists or has occurred. Inspections made pursuant to this Section need not be limited to matters referred to in the complaint.

c) No licensee or registrant shall discharge or in any manner discriminate against any worker because such worker has filed any complaint or instituted or caused to be instituted any proceedings under this Part or has testified or is about to testify in any such proceeding or because of the exercise by such worker on behalf of himself or others of any option afforded by this Part. Furthermore, each licensee and registrant shall instruct his contractors and subcontractors not to discharge or in any manner discriminate against any worker because such worker has filed any complaint or instituted or caused to be instituted any proceedings under this Part or has testified or is about to testify in any such proceeding or because of the exercise by such worker on behalf of himself or others any option afforded by this Part. Any worker who believes that he has been so discharged or discriminated against may file a complaint with the Department alleging a violation of this subsection.

(Source: Amended at ___ Ill. Reg._____, effective _____)

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: STANDARDS FOR PROTECTION AGAINST RADIATION

2) Code Citation: 32 Ill. Adm. Code 340

3) Section Number: 340.4010 — Proposed Action: Amendment

4) Statutory Authority: Implementing and authorized by Section 16 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1990 Supp., ch. 111½, par. 210-16).

5) A Complete Description of the Subjects and Issues Involved: The Department is amending this Part to change the cross references to other rules of the Department. Rather than listing the other rules individually by Part number, the Department is proposing to cross reference to 32 Ill. Adm. Code: Chapter II, Subchapters b and d. It is the Department's intent to refer to all Department rules related to radiation protection, low-level radioactive waste and transportation. In addition, the Department is adding lead in phrases to Section 340.4010(a) and (c). This is necessary to conform to the Secretary of State's format requirements for rules.

6) Will this proposed amendment replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: The requirements imposed by the proposed rulemaking are not expected to require local governments to establish, expand, or modify their activities in such a way as to necessitate additional expenditures from local revenues.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this notice. The Department will consider fully all written comments on this proposed rulemaking submitted during the 45 day comment period. Comments should be submitted to:

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENT

Betsy Salus
Senior Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 785-9881 (voice)
(217) 785-9900 (TDD)

12) Initial Regulatory Flexibility Analysis:

A) Date rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: February 11, 1992

B) Types of small businesses affected: The Department believes that these amendments impose no direct impact on any small businesses that are licensed by the Department to possess, use, distribute, store, treat, or dispose of radioactive materials.

C) Reporting, bookkeeping or other procedures required for compliance: This rulemaking only corrects the references in this section, and consequently does not require licensees to perform reporting, bookkeeping or other procedures for achieving compliance.

D) Types of professional skills necessary for compliance: No particular professional skills are necessary for compliance.

The full text of the Proposed Amendment begins on the next page:

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENT

TITLE 32: ENERGY
CHAPTER II: DEPARTMENT OF NUCLEAR SAFETY
SUBCHAPTER b: RADIATION PROTECTION

PART 340
STANDARDS FOR PROTECTION AGAINST RADIATION

SUBPART A: GENERAL

Section
340.1000 Purpose and Scope
340.1010 Radiation Dose Standards for Individuals in Restricted Areas
340.1020 Determination of Accumulated Dose
340.1030 Exposure to Concentrations of Radioactive Material in Air in Restricted Areas
340.1040 Exposure of Minors
340.1050 Permissible Levels of Radiation for External Sources in Unrestricted Areas
340.1060 Concentration of Radioactivity in Effluents to Unrestricted Areas
340.1070 Orders Requiring Furnishing of Bioassay Service

SUBPART B: PRECAUTIONARY PROCEDURES

Section
340.2010 Surveys
340.2020 Personnel Monitoring
340.2030 Caution Signs, Labels, and Signals
340.2040 Exceptions from Posting and Labeling Requirements
340.2050 Instruction of Personnel
340.2060 Storage and Control of Sources of Radiation
340.2070 Procedures for Picking Up, Receiving, and Opening Packages

SUBPART C: WASTE DISPOSAL

Section
340.3010 General Requirements
340.3020 Method of Obtaining Approval of Proposed Disposal Procedures
340.3030 Disposal by Release Into Sanitary Sewage Systems
340.3040 Land Disposal
340.3050 Disposal by Incineration
340.3060 Disposal of Specific Wastes
340.3070 Classification of Radioactive Waste for Land Disposal

AUTHORITY: Implementing and authorized by Section 16 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. ~~1985~~ 1990 Supp., ch. 111½, pars. ~~211 et seq.~~ 210-16).

SOURCE: Filed April 24, 1970 by the Department of Public Health; transferred to the Department of Nuclear Safety by P.A. 81-1516, effective December 3, 1980; amended at 5 Ill. Reg. 9586, effective September 10, 1981; codified at 7 Ill. Reg. 16027; Recodified at 10 Ill. Reg. 11273; amended at 10 Ill. Reg. 17538, effective September 25, 1986; amended at __ Ill. Reg. _____, effective _____.

Section 340.4010 Records of Surveys, Radiation Monitoring, and Disposal

a) Each licensee or registrant shall maintain personnel monitoring records as described below:

1) Each licensee or registrant shall maintain records showing the radiation exposures of all individuals for whom personnel monitoring is required under Section 340.2020 of this Part,

and shall report to the Department at intervals prescribed by the Department, each quarterly radiation dose which exceeds 25% of the limits specified in Section 340.1010(a) for each monitored person, except for persons under 18 years of age, in which case all monthly doses shall be reported on a monthly basis. Such records shall be kept on Form RMA-1/RMA-2 in accordance with the instructions contained on the form, or on clear and legible records containing all the information required by Form RMA-1/RMA-2. The doses entered on the form or records shall be for periods of time not exceeding one calendar quarter and one month respectively. Reports submitted to the Department shall be on Form RMA/RMA-2 or a facsimile approved by the Department.

2) No licensee or registrant shall subtract radiation exposures from official personnel monitoring records without the prior approval of the Department.

b) Each licensee or registrant shall maintain records in the same units used in this Part, showing the results of surveys required by Section 340.2010, monitoring required by Sections 340.2070(b) and (c), and disposals made under Sections 340.3020, 340.3030, 340.3040 and 32 Ill. Adm. Code 601.

c) Each licensee or registrant shall maintain records as described below:

1) Records of individual exposure to radiation and to radioactive material which must be maintained pursuant to the provisions of Section 340.4010(a) and records of bioassays, including results of whole body counting examinations, made pursuant to Section 340.1070 shall be preserved until the Department authorizes their disposition.

2) Records of the results of surveys and monitoring which must be maintained pursuant to Section 340.4010(b) shall be preserved for 2 years after completion of the survey except that the following records shall be maintained until the Department authorizes their disposition:

A) records of the results of surveys to determine compliance with Section 340.1030(a);

B) in the absence of personnel monitoring data, records of the results of surveys to determine external radiation dose; and

DEPARTMENT OF NUCLEAR SAFETY

NOTICE OF PROPOSED AMENDMENT

C) records of the results of surveys used to evaluate the release of radioactive effluents to the environment.

3) Records of disposal of licensed material made pursuant to Section 340.3020, 340.3030, 340.3040, 340.3050, 340.3060 and 32 Ill. Adm. Code 601 are to be maintained until the Department authorizes their disposition.

4) Records which must be maintained pursuant to this Part may be the original or either a high quality copy or microform provided that such reproduced copy or microform is duly authenticated by authorized personnel and the microform is capable of producing a legible copy after storage for the period specified by 32 Ill. Adm. Code ~~310, 320, 330, 331, 341, 350, 351, and 601~~: Chapter II, Subchapters b and d.

5) If there is a conflict between the Department's regulations in this Part, license condition, or other written Department approval or authorization pertaining to the retention period for the same type of record, the retention period specified in the regulations in this Part for such records shall apply unless the Department, pursuant to 32 Ill. Adm. Code 310.30(a), has granted a specific exemption from the record retention requirements specified in the regulations in this Part.

d) The discontinuance of, or curtailment of, activities does not relieve the licensee or registrant of responsibility for retaining all records required by Section 340.4010. A licensee or registrant may, however, request the Department to accept such records. The acceptance of the records by the Department relieves the licensee or registrant of subsequent responsibility only in respect to their preservation as required in Section 340.4010.

(Source: Amended at __ Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

1) The Heading of the Part: Practice In Administrative Hearings

2) Code Citation: 89 Ill. Adm. Code 104

3) Section Numbers: Proposed Action:

104.206	Amendment
104.208	Amendment
104.210	Amendment
104.272	Amendment
104.273	Amendment
104.274	Amendment

4) Statutory Authority: Sections 12-4.25 and 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 12-4.25 and 12-13)

5) A Complete Description of the Subjects and Issues Involved: These amendments allow the Department to recover overpayments from vendors and to terminate eligibility to participate in the Medical Assistance Program because of a loss of license, certification or other authorization or because of a conviction for a violation of the Public Aid Code prior to the full evidentiary hearing. They also provide that any money so recovered would be repaid to the vendor if it is not determined at the hearing that recovery was warranted.

6) Will these Proposed Amendments replace an Emergency Amendment currently in effect? No

7) Does this rulemaking contain an automatic repeal date?
____Yes __X__No

8) Do these Proposed Amendments contain incorporations by reference? No

9) Are there any other Proposed Amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking has no effect on local government units.

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning the proposed rulemaking. All comments must be in writing and should be addressed to Daniel Leikvold, Staff Attorney, Office of the General Counsel, Illinois Department of Public Aid, Jesse B. Harris Building II, 100 South Grand Avenue East, 3rd Floor, Springfield, Illinois 62762 (217) 782-1233. The Department will consider all written comments it receives within 30 days of the date of publication of this notice.

12) Initial Regulatory Flexibility Analysis:

A) Date Proposed Amendment was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: February 11, 1992

B) Types of small businesses affected: Medical Providers

C) Reporting, bookkeeping or other procedures required for compliance: No new procedures required.

D) Types of professional skills necessary for compliance: No new skills required.

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER a: GENERAL PROVISIONS

PART 104
PRACTICE IN ADMINISTRATIVE HEARINGS

SUBPART A: ASSISTANCE APPEALS

Section
104.1 Assistance Appeals
104.10 Initiation of Appeal Process
104.11 Pre-Appeal Review
104.12 Notice of Hearing
104.20 Conduct of Hearings
104.21 Representation
104.22 Appellant Participation in Hearing
104.23 Evidentiary Requirements
104.30 Subpoenas
104.35 Amendment of Appeal
104.40 Consolidation of Appeals
104.45 Postponement or Continuation of Hearings
104.50 Withdrawal of Appeal
104.55 Closing of Hearing Record
104.60 Dismissal of Appeal
104.70 Final Administrative Decision
104.80 Public Aid Committee

SUBPART B: RESPONSIBLE RELATIVE AND JOINT PAYEE PETITIONS

Section
104.100 Responsible Relative and Joint Payee Petitions
104.101 Petition for Hearing
104.102 Conduct of Administrative Support Hearings
104.103 Conduct of Hearings to Contest the Determination of Past-Due Support or of Share of Jointly-Owned Funds
104.104 Conduct of Hearings to Stay Service of an Administrative Order for Withholding or Notice of Delinquency, or to Modify, Suspend or Terminate an Administrative Order for Withholding

SUBPART C: MEDICAL VENDOR HEARINGS

Section
104.200 Applicability
104.202 Definitions
104.204 Notice of Denial of An Application
104.206 Notice of Intent to Recover Money

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

SUBPART D: RULES FOR JOINT DEPARTMENT ACTIONS AGAINST SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES PARTICIPATING IN THE MEDICAID PROGRAM

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

SUBPART E: FOOD STAMP ADMINISTRATIVE DISQUALIFICATION HEARINGS

SUBPART F: INCORPORATION BY REFERENCE

AUTHORITY: Implementing Sections 11-8 et seq., 12-4.9 and 12-4.25 and authorized by Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, pars. 11-8 et seq., 12-4.9, 12-4.25 and 12-13)

SOURCE: Filed and effective December 30, 1977; emergency rule at 2 Ill. Reg. 11 pg. 151 effective March 9, 1978 for a maximum of 150 days; amended at 2 Ill. Reg. 33, p. 57, effective August 17, 1978; peremptory amendment at 3 Ill. Reg. 11, p. 38 effective March 1, 1979; amended at 4 Ill. Reg. 21, p. 80, effective May 8, 1980; peremptory amendment 5 Ill. Reg. 1197, effective January 23, 1981; amended at 5 Ill. Reg. 10753 effective October 1, 1981; amended at 6 Ill. Reg. 894, effective January 7, 1982; codified at 7 Ill. Reg. 5706; amended at 8 Ill. Reg. 5274, effective April 9, 1984; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 16979; amended at 8 Ill. Reg. 18114, effective September 21, 1984; amended at 10 Ill. Reg. 10129, effective June 1, 1986; amended at 11 Ill. Reg. 9213, effective April 30, 1987; amended at 12 Ill. Reg. 9142, effective May 16, 1988; amended at 13 Ill. Reg. 3944, effective March 10, 1989; amended at 13 Ill. Reg. 17013, effective October 16, 1989; amended at 14 Ill. Reg. 18836, effective November 9, 1990; amended at 15

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

Ill. Reg. 5320, effective April 1, 1991; amended at 15 Ill. Reg. 6557, effective April 30, 1991; amended at 16 Ill. Reg. ____, effective _____.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

SUBPART C: MEDICAL VENDOR HEARINGS

Section 104.206 Notice of Intent to Recover Money

If the Department intends to recover money it shall notify the vendor in writing, setting forth:

a) the reason for the Department's action,

b) a statement of the right to request a hearing ~~prior to recovery~~,

c) a statement of the time, place and nature of the hearing,

d) a statement of the legal authority and jurisdiction under which the hearing is to be held, ~~and~~

e) a reference to the sections of the statutes and rules involved~~.~~,

f) a statement that the vendor has the opportunity to respond prior to the recovery and a statement of how and to whom such a response should be made, and

g) the date after which the Department will start to recover money by deducting from Department obligations to the vendor and a statement that the Department will recover the money in this manner prior to the completion of any hearing requested and that any money so recovered will be repaid to the vendor if it is not determined at hearing that the recovery was warranted.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

Section 104.208 Notice of Intent to Terminate, Suspend or Not Renew Provider Agreement

a) If, in an action other than one under 89 Ill. Adm. Code 140.16(a)(2) or one under 140.16(a)(9) based on a conviction for a violation of the Public Aid Code, the Department of Public Aid (Department) intends to

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Section 104.208 Notice of Intent to Terminate, Suspend or Not Renew Provider Agreement (Cont'd)

terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, or terminate (or not renew) a vendor's provider agreement, it shall notify the vendor in writing, setting forth:

1) the reason for the Department's action,

2) a statement of the right to request a hearing prior to the intended action taking effect,

3) a statement of the time, place and nature of the hearing,

4) a statement of the legal authority and jurisdiction under which the hearing is to be held, and

5) a reference to the sections of the statutes and rules involved.

b) If, in an action under 89 Ill. Adm. Code 140.16(a)(2) or one under 140.16(a)(9) based on a conviction for a violation of the Public Aid Code, the Department intends to terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, or terminate (or not renew) a vendor's provider agreement, it shall notify the vendor in writing, setting forth:

1) the reason for the Department's action,

2) the effective date of the action,

3) a statement that the vendor has the opportunity to respond prior to the effective date and a statement of how and to whom such a response should be made,

4) a statement that the action will be effective on such date regardless of whether any hearing requested has been completed,

5) a statement of the right to request a hearing,

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Section 104.208 Notice of Intent to Terminate, Suspend or Not Renew Provider Agreement (Cont'd)

6) a statement of the time, place and nature of the hearing,

7) a statement of the legal authority and jurisdiction under which the hearing is to be held, and

8) a reference to the sections of the statutes and rules involved.

cb) The notice shall also inform the vendor, where applicable, that the final administrative decision of the Department could result in suspension for a specific period of time as well as termination.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

Section 104.210 Right to Hearing

a) A vendor may request a hearing within 10 days after the vendor's receipt of the Department's notice of:

1) the Department's decision to deny an application; (as provided in Section 104.204);

2) the Department's intent to recover money (as provided in Section 104.206); or

3) the Department's intent to terminate or suspend a vendor's eligibility or terminate (or not renew) a vendor's provider agreement (as provided in Section 104.208).

b) A request for hearing must be received by the Department within 10 days of the date on which the vendor received the Department's notice.

c) This request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged.

d) If such a request is not received within 10 days, or is received but later withdrawn, the Department's decision and the grounds asserted as the basis

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Section 104.210 Right to Hearing (Cont'd)

therefor in the notice shall be a final and binding administrative determination.

e) In actions initiated pursuant to Section 104.206 or 104.208(b), if a vendor requests a hearing, such a request shall not delay the effective date of action set forth in the Notice. In all other actions initiated pursuant to 104.204 or 104.208, the action shall not take place until the final administrative decision has been issued.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

Section 104.272 Withholding of Payments During Pendency of Proceedings

a) Payments on pending and subsequently submitted bills may be withheld during the pendency of the administrative proceeding, except that if a final administrative decision has not been issued within 120 days of service of the notice of intent to terminate, unless delay has been caused by the vendor, payment can no longer be withheld. Payments will be released at the end of the 120 days subject to setoff for recovery of the amount sought in the proceeding.

b) This 120 day limit may be extended if:

1) The extension is mutually agreed to by the Department and the vendor.

2) If delay has been caused by the vendor, the 120 day limit will be extended by the number of days the vendor has caused the proceeding to be delayed. Whenever a request by the vendor or his authorized representative to continue or reschedule a hearing results in a hearing session being held subsequent to the date originally set by the Department for such hearing session, such request shall constitute a delay caused by the vendor equal to the number of days between the new hearing date and the date originally scheduled. Approval of any of the following or other similar requests will also be considered a delay caused by the vendor:

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NOTICE OF PROPOSED AMENDMENTS

Section 104.272 Withholding of Payments During Pendency of Proceedings (Cont'd)

A) that a period of preparation for written submissions or oral arguments be allowed;

B) that the time for filing written exceptions under the 89 Ill. Adm. Code 140.290 be extended.

c) If the vendor is terminated as a result of final agency action, payments or credit for any services rendered subsequent to receipt of the notice of intent to terminate shall be denied. The vendor will receive payment or credit for services rendered prior to receipt of the notice of intent to terminate subject to setoff for recovery of the amount sought in the proceeding.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

Section 104.273 Continuation of Payments During Pendency of Proceedings

The Department will continue to make payments during the pendency of an administrative proceeding in the following circumstances:

a) Federal or State law or regulation does not require such payments to be withheld, and

b) 1) If the vendor is a nursing home, the Department will continue to make payments for services rendered to persons continuously eligible for and receiving Medical Assistance and residing in the home on the date of the Department's notice initiating the administrative proceeding; or

2) If the vendor is a hospital, the Department will continue to make payments for services rendered to hospitalized persons who are eligible for and receiving Medical Assistance on the date of the Department's notice initiating the administrative proceeding; or

3) If the administrative proceeding only relates to recovery of money (and not termination ~~or suspension~~), the Department will continue to ~~make~~ payments process invoices for services rendered by the vendor subject to setoff for recovery of the amount sought in the proceeding, ~~unless the Director of the Department decides that failure to withhold will result in the potential permanent loss of State funds (for example, if the vendor is about to leave the State or is about to become insolvent)~~.

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Section 104.273 Continuation of Payments During Pendency of Proceedings (Cont'd)

4) If the administrative proceeding only relates to suspension and not termination of eligibility, the Department will continue to make payments for services rendered by the vendor.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

Section 104.274 Denial of Payments for Services During Pendency of Proceedings

a) If the vendor is terminated as a result of final agency action, payments or credit for any services rendered subsequent to receipt of the notice of intent to terminate shall be denied unless:

1a) Pursuant to Section 104.273, payments were not withheld; or

2b) Pursuant to Section 104.272, previously withheld payments for such services had been released because the administrative proceeding had been pending for more than 120 days.

b) In actions initiated pursuant to Section 104.208(b), if the vendor is terminated as a result of final agency action, payments or credit for any services rendered subsequent to receipt of the notice of intent to terminate shall be denied regardless of whether or not any hearing requested is completed in 120 days.

(Source: Amended at 16 Ill. Reg. _____, effective _____)

COMMISSIONER OF SAVINGS AND LOAN ASSOCIATIONS

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Residential Mortgage License Act of 1987

2) Code Citation: 38 Ill. Adm. Code 450

3)

Section Numbers	Proposed Action
450.440	Amendment
450.1010	Amendment
450.1250	Amendment
450.1335	Amendment
450.1340	Amendment

4) Statutory Authority:

Implementing and authorized by the Residential Mortgage License Act of 1987 (Ill. Rev. Stat. 1989, ch. 17, par. 2324-1(g)).

5) A Complete Description of the Subjects and Issues Involved:

The rules in this Part implement the Residential Mortgage License Act of 1987 (Ill. Rev. Stat. 1989, ch. 17, pars. 2321-1 et seq.) which creates a thorough regulatory structure and consumer protection provision that recognizes the growing complexity and volume of mortgage banking in Illinois.

These amendments represent the culmination of a comprehensive review by the Agency. The Agency has found that major secondary market investors (for instance, the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC)), allow deposit of escrow funds in other institutions as delineated in the emergency amendment to Section 450.440 of this Part. It has come to the attention of the Agency that the present wording of this Section created a restriction which hindered prudent business practices while providing no demonstrable benefit to borrowers.

With little warning, mortgage interest rates have been undergoing a period of wide fluctuation, including reduction and increase. Historically, declining interest rates have resulted in an extraordinary volume of mortgage loan applications. This volume is artificially inflated by the practice of multiple applications, resulting in multiple appraisal, credit reporting and title company orders for the same property. The duplication creates a demand for processing services which the market realistically cannot meet. Consequently, many homeowners or prospective home

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purchasers are frustrated in their attempts to obtain timely financing. Accordingly, the Agency is filing an emergency amendment to Section 450.1335. In essence, the amendment discourages multiple mortgage applications; because the mortgage loan applicant will have a vested financial interest in his/her application, through the payment of a competitively priced upfront fee to lock in an interest rate. Simultaneously, to avoid problems which arose in 1986 and 1987 from similar situations, the Agency has mandated explicit standards under which such fee may be collected.

The proposed changes include the following Sections:

450.440 Escrow: The amendment to this section is twofold: a technical amendment for consistency with the amendment to Section 450.1335, plus a broader definition of the institutions into which escrow funds may be deposited.

450.1010 Loan Brokerage Agreement: Technical amendment for consistency with the amendment to Section 450.1335.

450.1250 Good Faith Requirements: Technical amendment for consistency with the amendment to Section 450.1335.

450.1335 Fees and Charges Prior to Closing: The amendment replaces the "True-Rate Lock In" provision with a "Rate-Lock Fee" which can be collected by a Licensee, provided a written Rate-Lock Fee Agreement states certain specific information with respect to the terms of the mortgage. Further, the amendment requires that such fee shall be deposited in escrow.

450.1340 Refunds on Failure to Close: Technical amendment for consistency with the amendment to Section 450.1335.

6) Will these Proposed Amendments replace Emergency Amendments currently in effect? Yes

7) Does this rulemaking contain an automatic repeal date?
___Yes X No

8) Do these Proposed Amendments contain incorporations by reference? No

9) Are there any other Proposed Amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking has no effect on local governmental units.

COMMISSIONER OF SAVINGS AND LOAN ASSOCIATIONS

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11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Any interested parties should submit written comments or views concerning the proposed rulemaking to the attention of:

Mr. Jay R. Stevenson, Deputy Commissioner
Illinois Commissioner of Savings and Residential
Finance (Formerly the Commissioner of Savings and
Loan Associations)
500 East Monroe Street, Suite 800
Springfield, Illinois 62701-1509
Telephone: (217) 782-6169

The Agency will consider all written comments it receives within 45 days of the date of publication of this Illinois Register.

12) Initial Regulatory Flexibility Analysis:

A) Date rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: February 10, 1992.

B) Types of small business affected: Entities engaged in residential real estate mortgage lending activities as described in the Residential Mortgage License Act of 1987. The entities include those engaged, for a fee, in soliciting, brokering, originating, funding or servicing loans secured by mortgages on residential real estate.

C) Reporting, bookkeeping or other procedures required for compliance: The amendments require minimal additional recordkeeping and disclosures.

D) Types of professional skills necessary for compliance: The proposed amendments do not require additional professional skills for compliance. The present Act and Rules have created uniform procedures for residential mortgage lending that require a level of professional and ethical business practices that are commensurate with those of other regulated entities in the financial services industry engaged in residential mortgage lending.

The full text of the Proposed Amendments are identical to the text of the Emergency Amendments which appears in this issue of the Illinois Register on Page 2918 .

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of Part: Minimum Standards for Individual and Group Medicare Supplement Insurance

2) Code Citation: 50 Ill. Adm. Code 2008

3)

Section Number:	Adopted Action:
2008.10	Amended
2008.20	Amended
2008.30	Amended
2008.40	Amended
2008.50	Amended
2008.60	Amended
2008.61	Repealed
2008.70	Amended
2008.71	Renumbered, New Section
2008.72	New Section
2008.73	New Section
2008.74	New Section
2008.75	Renumbered, New Section
2008.80	Amended
2008.81	Repealed, New Section
2008.82	Amended
2008.90	Amended
2008.100	Amended
2008.101	Amended
2008.102	Amended
2008.103	Amended
2008.104	Amended
2008.110	Amended
2008.APPENDIX A	Amended
2008.APPENDIX B	Amended
2008.APPENDIX C	Renumbered, New Section
2008.APPENDIX D	Repealed, New Section
2008.APPENDIX E	Renumbered, New Section
2008.APPENDIX F	New Section
2008.APPENDIX G	New Section
2008.APPENDIX H	New Section
2008.APPENDIX I	New Section
2008.APPENDIX J	New Section
2008.APPENDIX K	New Section
2008.APPENDIX L	New Section
2008.APPENDIX M	Renumbered, Amended
2008.APPENDIX N	Repealed, New Section
2008.APPENDIX O	Renumbered, Amended
2008.APPENDIX P	New Section

4) Statutory Authority: Implementing Sections 363 and 363a and authorized by Section 401 of the Illinois Insurance Code (Ill. Rev. Stat. 1990 Supp., ch. 73, pars. 975, 975a as amended by P.A. 87-0601 effective September 19, 1991, and par. 1013).

5) Effective Date of amendment: February 11, 1992

6) Does this rulemaking contain an automatic repeal date? No

7) Does this amendment contain incorporations by reference? No

8) Date filed in Agency's Principal Office: February 11, 1992

9) Notice of Proposal Published in Illinois Register:

October 18, 1991, 15 Ill. Reg. 14859

10) Has JCAR issued a Statement of Objections to this rule? No

11) Difference(s) between proposal and final version:

a) Section Index - 2008.71 - On line two the words "or Delivered" have been inserted between the words "Issued" and "on".

b) Section Index - 2008.72 - The word "Supplement" has been inserted between the words "Medicare" and "Benefit".

c) AUTHORITY Note - On the first line the parenthesis that surrounded the small "a" have been deleted. Also, the abbreviated form of he word paragraph has been inserted on the last line between "and" and "1013".

d) Main SOURCE Note - On line three the word "amendments" has been made singular.

e) Section 2008.10 - On line six the word "Section" has been made plural and the parenthesis surrounding the small "a" have been deleted.

f) Section 2008.20 - This Section has been titled "Purpose" to be consistent with the index.

g) Section 2008.30(a)(1) - On line two the comma following the word "delivered" has been deleted and "or" has been inserted. Also, the semicolon on line four has been deleted.

h) Section 2008.50 - "Benefit Period" - On line two the word "as" has been deleted following the word "than".

i) Section 2008.50 - "Duplication of Insurance" - On line four the semicolon following the word "issuer" has been changed to a comma.

j) Section 2008.50 - "Health Care Expenses" - Following the first full paragraph, all the semicolons have been changed to commas.

k) Section 2008.50 - "Sickness" - On the first line the words "to be" have been deleted and "ly" has been added to the word "restrictive".

l) Section 2008.70(a)(1) - On line four the word "it" has been deleted and the words "the losses" have been inserted in lieu thereof.

m) Section 2008.71(a)(1) - On line four the word "it" has been deleted and the words "the losses" have been inserted in lieu thereof.

n) Section 2008.71(a)(5)(C)(ii) - The word "meets" has been made singular.

o) Section 2008.71(c)(5) - On line five the word "state" has been capitalized.

p) Section 2008.71(c) 11 - On line six the words "new or innovative" have been deleted.

q) Section 2008.72(b) - On line four the word "Section" has been made plural and the words "in Section" at the end of line four have been deleted.

r) Section 2008.73(i)(6) - On line one the word "rights" has been made singular and the word "of" at the end of the line has been changed to "to".

s) Section 2008.75(a) - On line five a closing parenthesis has been added to the OBRA citation.

t) Section 2008.80(d)(1) - On line five, the word "are" has been inserted between the words "as" and "necessary".

u) Section 2008.82(a) - On line three the words "or other representative" have been deleted.

v) Section 2008.82(c) - On lines six, seven and eight, the language which had been stricken is now being retained.

w) Section 2008.90(a)(5) - The comma at the end of the first line has been deleted.

x) Section 2008.90(c)(1) and (2) - On line three of number one, the language "every insurer" which had been stricken is now being retained. Also, on the last line of number two, parenthesis have been added to surround the number "12" and the word "twelve" has been added.

y) Section 2008.90(d)(2) - In the indented paragraph, on line three, a comma has been added following the word "application".

z) Section 2008.90(e) - In the indented paragraph, on line five, a comma has been added following the word "Medicare".

aa) Section 2008.100(a) - On the second to the last line, the comma following the word "producer" has been deleted.

bb) Section 2008.100(a)(4) - On the first line the word "state" has been capitalized.

cc) Section 2008.100(d) - On line nine, the comma following the word "producer" has been deleted.

dd) Section 2008.100(f) - On the first line following the number "2" the words "of Appendix M" have been added and the words "above of the replacement notice" have been deleted.

ee) Section 2008.101(a)(1) - The subsection has been rewritten as follows:

"Establish fair and accurate marketing procedures which comply with the standards set forth in Sections 363a(5) and (6) of the Code."

ff) Section 2008.102(a) - On line two, a comma has been inserted following the word "certificate".

gg) Section 2008.110 - On line three, the word "the" has been deleted following the word "of".

hh) Section 2008.APPENDIX B - APPENDIX P - The Appendix headings have been made consistent with the Section index.

ii) Section 2008.APPENDIX N - A typographical error has been corrected under number 13, in the second paragraph, on the first line, the word "one" has been changed to "on".

jj) Section 2008.APPENDIX O - A typographical error has been corrected on the second page of this appendix. In the first paragraph following the table, on the first line the word "aded" has been changed to "added".

12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this amendment replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of rulemaking: The Department has initiated these amendments pursuant to a federal statutory requirement. Under Section 4355 and 4357 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508), the requirements set forth in Section 2008.74 and 2008.80(a) concerning Open Enrollment and Loss Ratio Standards are effective November 5, 1991. Under Section 4351 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508), the NAIC has adopted a model regulation which sets standards for individual and group Medicare supplement insurance. Under the Act the states must promulgate rules which mirror the NAIC model within one year of the model's adoption. The NAIC adopted the Medicare model on July 30, 1991.

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NOTICE OF ADOPTED AMENDMENTS

16) Information and questions regarding this adopted amendment shall be directed to:

Charles J. Budinger
Department of Insurance
320 West Washington
Springfield, Illinois 62767

The full text of the Adopted Amendment begins on the next page.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2008
MINIMUM STANDARDS FOR INDIVIDUAL AND GROUP
MEDICARE SUPPLEMENT INSURANCE

2008.APPENDIX B Outline of Medicare Supplement Coverage-Cover Page
2008.APPENDIX C Notice-to-Applicant-Regarding-Replacement-of Medicare-Supplement-Insurance-(Response-Other Than-Direct) Plan A
2008.APPENDIX D Notice-to-Applicant-Regarding-Replacement-of Medicare-Supplement-Insurance-(Direct-Response) Plan B
2008.APPENDIX E Notice-on-Medicare-Changes---1990 Plan C
2008.APPENDIX F Plan D
2008.APPENDIX G Plan E
2008.APPENDIX H Plan F
2008.APPENDIX I Plan G
2008.APPENDIX J Plan H
2008.APPENDIX K Plan I
2008.APPENDIX L Plan J
2808.APPENDIX C 2008.APPENDIX M Notice to Applicant Regarding Replacement of Medicare-Supplement Accident and Sickness Insurance (Response Other Than Direct)
2888.APPENDIX D 2008.APPENDIX N Notice-to-Applicant-Regarding Replacement-of-Medicare-Supplement-Insurance (Direct-Response) Medicare Supplement Refund Calculation Format
2888.APPENDIX E 2008.APPENDIX O Notice on Medicare Changes - 1998
2008.APPENDIX P Medicare Supplement Policies Report

AUTHORITY: Implementing Sections 363 and 363(a) and authorized by Section 401 of the Illinois Insurance Code (Ill. Rev. Stat. 1989 1990 Supp., ch. 73, pars. 975, 975a as amended by P.A. 87-0601 effective September 19, 1991, and par. 1013).

SOURCE: Adopted at 6 Ill. Reg. 7115, effective June 1, 1982; adopted at 6 Ill. Reg. 7115, effective January 1, 1983; codified at 7 Ill. Reg. 3474; emergency amendment at 13 Ill. Reg. 586, effective January 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 8520, effective May 23, 1989; amended at 14 Ill. Reg. 19243, effective November 27, 1990; amended at 16 Ill. Reg. 2766, effective February 11, 1992.

Section 2008.10 Authority

This Part is issued by the Director of Insurance pursuant to Section 401 of the Illinois Insurance Code (Ill. Rev. Stat. 1989 1990 Supp., ch. 73, par. 1013) which empowers the Director . . . to make reasonable rules and regulations as may be necessary for making effective . . ." the insurance laws of this

State. This Part implements Sections 363 and 363(a) of the Illinois Insurance Code (Ill. Rev. Stat. 1989 1990 Supp., ch. 73, pars. 975 and 975(a) as amended by P.A. 87-0601, effective September 19, 1991).

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.20 Purpose

The purpose of this Part is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare by-reason-of-age.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.30 Applicability and Scope

a) Except as otherwise specifically provided in Sections 2008.80 and 2008.81, this Part shall apply to:

   1) All Medicare supplement policies and-subscriber contracts delivered, or issued for delivery, renewed-or-amended in this State on or after the effective date hereof; and

   2) All certificates issued under group Medicare supplement policies or-subscriber-contracts, which policies or contracts have been delivered or issued for delivery in this State.

b) This Part shall not apply to:

   1) "Accident Only" or "Specified Disease" types of policies (Section 363(1)(b) of the Illinois Insurance Code (the Code)), or

   2) Policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies or plans are not

DEPARTMENT OF INSURANCE

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marketed or purported or held to be Medicare supplement policies or benefit plans (Section 363(1)(b) of the Code).

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.40 Definitions

For the purposes of this Part:

"Applicant" means:

in the case of an individual Medicare supplement policy ~~or subscriber contract~~, the person who seeks to contract for insurance benefits; and

in the case of a group Medicare supplement policy ~~or subscriber contract~~, the proposed certificateholder (Section 363(2)(a) of the Code).

"Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy ~~which certificate has been delivered or issued for delivery in this State~~ (Section 363(2)(b) of the Code).

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Code" means the Illinois Insurance Code (Ill. Rev. Stat. ~~1987~~ 1990 Supp., ch. 73, par. 613, et seq.).

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Supplement Policy" means a group or individual policy of Accident and Health insurance ~~or subscriber contract~~ delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation,

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prepaid health plan, or any similar organization which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare ~~by reason of age~~ (Section 363(2)(c) of the Code).

"Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.50 Policy Definitions and Terms

No ~~insurance~~ policy or ~~subscriber contract~~ certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or ~~subscriber contract~~ certificate contains definitions or terms which conform to the requirements of this Section.

"Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force."

Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no fault plan, unless prohibited by law.

"Benefit Period" or "Medicare Benefit Period" shall not be defined as more restrictive~~ly~~ than ~~as that~~ defined in the Medicare program.

"Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined ~~in relation~~

to-status-facilities-and-available-services more restrictively than as defined in the Medicare program.

A-definition-of-such-home-or-facility-shall-not-be-more restrictive-than-one-requiring-that-it:

be-operated-pursuant-to-law;

be-approved-for-payment-of-Medicare-benefits-or-be qualified-to-receive-such-approval;-if-so-requested;

be-primarily-engaged-in-providing;-in-addition-to room-and-board-accommodations;-skilled-nursing-care under-the-supervision-of-a-duly-licensed-physician;

provide-continuous-twenty-four-(24)-hours-a-day nursing-service-by-or-under-the-supervision-of-a registered-graduate-professional-nurse-(R.N.);-and

maintains-a-daily-medical-record-of-each-patient.

The-definition-of-such-home-of-facility-may-provide that-such-term-shall-not-be-inclusive-of:

any-home;-facility-or-part-thereof-used-primarily for-rest;

a-home-or-facility-for-the-aged-or-for-the-care-of drug-addicts-or-alcoholics;-or

a-home-or-facility-primarily-used-for-the-care-and treatment-of-mental-diseases-or-disorders;-or custodial-or-educational-care.

"Duplication of Insurance" means a transaction wherein new accident and health insurance is to be purchased and it is known to the agent producer or should be known to the agent producer or the insurer issuer, in the case of a direct response solicitation, that the new insurance will provide some of the benefits or coverages which the proposed insured already has under existing accident and health insurance.

"Health Care Expenses" means expenses of a nonprofit health, hospital or medical service corporation, prepaid health plan or similar organization associated with the

delivery of health care services in which providers of the health care services are reimbursed for such services on an other than fee for service basis which are analogous to incurred losses of insurers. Such expenses shall not include:

Home office and overhead costs,

Advertising costs,

Commissions and other acquisition costs,

Taxes,

Capital costs,

Administrative costs, or and

Claims processing costs.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals: but

The-definition-of-the-term-"hospital"-shall not be more restrictively than one-requiring-that-the-hospital: as defined in the Medicare program.

be-an-institution-operated-pursuant-to-law;-and

be-primarily-and-continuously-engaged-in-providing or-operating-medical-and-diagnostic-facilities; with-major-surgical-facilities-either-on-its-premises-or-in-facilities-available-to-the-hospital-on a-prearranged-basis;-under-the-supervision-of-a staff-of-duly-licensed-physicians-for-the-medical care-and-treatment-of-sick-or-injured-persons-on-an inpatient-basis-for-which-a-charge-is-made;-and

provide-twenty-four-(24)-hour-nursing-service-by-or under-the-supervision-of-registered-graduate-professional-nurses-(R.N.'s);

The-definition-of-the-term-"hospital"-may-state-that such-term-shall-not-be-inclusive-of:

convalescent, rest, or nursing home or facilities, or

facilities primarily affording custodial, educational or rehabilitory care,

facilities for the aged, drug addicts or alcoholics, or

any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

"Medicare" shall be defined in the policy and certificate as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended", including the "Medicare Catastrophic Coverage Act of 1988 (Section 363(2)(d) of the Code) or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare Eligible Expenses" shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions including: determinations of medical necessity, as are applicable to Medicare claims.

"Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

"Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such

terms require the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

"Over-Insurance" means "duplication" of insurance to such extent that the combination of the existing insurance and the proposed insurance would substantially exceed any loss reasonably expected to be incurred.

"Physician" may shall not be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws dealing with physician licensure more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined to be more restrictively than the following: "Sickness means sickness illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.60 Prohibited Policy Provisions

a) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

1) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

2) mental or emotional disorders, alcoholism and drug addiction;

3) illness, treatment or medical condition arising out of:

A) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

C) aviation;

4) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

5) benefits provided under Medicare, any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charges is normally made in the absence of insurance;

6) dental care or treatment;

7) eye glasses, hearing aids, and examination for the prescription or fitting thereof;

8) rest cures, custodial care, transportation and routine physical examinations;

9) territorial limitations;

provided, however, Medicare supplement policies may not contain, when issued, limitations or exclusions of the type enumerated above that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

a) Except for permitted preexisting condition clauses as described in Section 2008.70(a)(1) and Section 2008.71(a)(1) of this Part, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

c) The terms "Medicare Supplement", "Medigap" and words of similar import shall not be used unless the policy complies with this Part.

dc) No Medicare supplement insurance policy, contract or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.61 Benefit Conversion Requirements During Transition (Repealed)

a) Effective January 1, 1998, no Medicare supplement insurance policy, contract or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.

b) Benefits eliminated by operation of the Medicare Catastrophic Coverage Repeal Act of 1989, (42 U.S.C.S. §1385) transition provisions shall be restored.

c) For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2) ~~Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;~~

3) ~~Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;~~

4) ~~Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;~~

5) ~~Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) (42 CFR 489.87(a) 1988, no subsequent dates or editions) unless replaced in accordance with federal regulations (42 CFR 489.87(b) 1988, no subsequent dates or editions) or already paid for under Part A;~~

6) ~~Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out of pocket amount equal to the Medicare Part B deductible ($75);~~

7) ~~Effective January 1, 1998, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) (42 CFR 489.87(b) 1988, no subsequent dates or editions), unless replaced in accordance with federal regulations (42 CFR 489.87(b) 1988, no subsequent dates or editions) or already paid for under Part A, subject to the Medicare deductible amount;~~

(Source: Repealed at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.70 Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to the Effective Date of this Part

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State prior to the effective date of this Part. No ~~insurance~~ policy or ~~subscriber-contract~~ certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate ~~which does not meet~~ unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

a) General Standards.

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

1) A Medicare supplement policy or certificate may shall not ~~deny a claim~~ exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage ~~for~~ because the losses involved a pre-existing condition. The policy or certificate may shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2) A Medicare supplement policy or certificate may shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;.

3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes;.

4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

A) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or

B) be cancelled or nonrenewed by the ~~insurer~~ issuer solely on the grounds of deterioration of health;.

5) An insurer shall:

A) Except as authorized by the ~~commissioner~~ Director of Insurance for this ~~s~~State, an ~~insurer~~ issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (5)(D) below, the ~~insurer~~ issuer shall offer certificate holders an individual Medicare supplement policy. The ~~insurer~~ issuer shall offer the certificate holder at least the following choices:

(i) an individual Medicare supplement policy ~~which provides for continuation of the benefits contained in the group policy; and~~ currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 2008.70(b) of this Part.

C) If a membership in a group is terminated, the ~~insurer~~ issuer shall:

(i) offer the certificateholder such conversion opportunities as are described in Paragraph ~~(b)~~ subsection (5)(B) above; or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding ~~insurer~~ issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

b) Minimum Benefit Standards.

1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare

Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$75100] maximum benefit.

7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) (42 CFR 409.87(a) 1988, no subsequent dates or editions) unless replaced in accordance with federal regulations (42 CFR 209.87(b) 1988, no subsequent dates or editions) or already paid for under Part A, subject to the Medicare deductible amount.

~~c) Medicare-Eligible-Expenses.~~

~~Medicare-eligible-expenses-shall-mean-health-care expenses-of-the-kinds-covered-by-Medicare,-to-the extent-recognized-as-reasonable-by-Medicare.--Payment of-benefits-by-insurers-for-Medicare-eligible-expenses may-be-conditioned-upon-the-same-or-less-restrictive payment-conditions,-including-determinations-of-medical necessity-as-are-applicable-to-Medicare-claims.~~

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.71 ~~Standards-for-Claims-Payment~~ Benefit Standards for Policies or Certificates Issued or Delivered on or after the Effective Date of this Part

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery

in this State on or after the effective date of this Part. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

a) General Standards

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because the losses involved a pre-existing condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5) Each Medicare supplement policy shall be guaranteed renewable; and

A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 2008.71(a)(5)(E), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for such benefits as otherwise meet the requirements of this subsection.

D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in Section 2008.71(a)(5)(C), or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy

was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

7) A Medicare supplement policy or certificate shall provide:

A) That benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

C) Reinstitution of such coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

b) Standards for Basic ("Core") Benefits Common to All Benefit Plans

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

c) Standards for Additional Benefits

The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 2008.72 of this Part.

1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.

6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or illness of sudden and unexpected onset.

9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

A) An annual clinical preventive medical history and physical examination that may include tests and services from subsection (B) below and patient education to address preventive health care measures.

B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Fecal occult blood test and/or digital rectal examination;

(ii) Mammogram;

(iii) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(iv) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(v) Serum cholesterol screening (every five (5) years);

(vi) Thyroid function test;

(vii) Diabetes screening.

C) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten (10) years).

D) Any other tests or preventive measures determined appropriate by the attending physician.

E) Reimbursement shall be for the actual charges up to one hundred (100) percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means an individual employed by an organization that is a Medicare certified home health agency, and is

accredited through a national accrediting organization such as the Joint Commission on Accreditation of Health Organizations (JCAHO), or the National League for Nursing (NLN), or the National Home Care Council (NHCC), and is licensed where state law requires.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

B) Coverage Requirements and Limitations

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved Home Care Plan of Treatment.

The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

One thousand six hundred dollars ($1,600) per calendar year.

Seven (7) visits in any one week.

Care furnished on a visiting basis in the insured's home.

Services provided by a care provider as defined in this Section.

At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

11) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

(Source: Section 2008.71 renumbered to Section 2008.75, new Section 2008.71 adopted at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.72 Standard Medicare Supplement Benefit Plans

a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 2008.71 of this Part.

b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this State, except as may be permitted in Sections 2008.71(c)(11) and 2008.73 of this Part.

c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in Appendix B and conform to the definitions in Section 2008.40 of this Part. Each benefit shall be structured in accordance with the format provided in Sections 2008.71 (b) and (c) and list the benefits in the order shown in Appendix B. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

d) An issuer may use, in addition to the benefit plan designations required in subsection (c) above, other designations to the extent permitted by law.

e) Make-up of benefit plans:

1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to all Benefit Plans, as defined in Section 2008.71(b) of this Part.

2) Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible as defined in Section 2008.71(c)(1).

3) Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus

the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 2008.71(c)(1), (2), (3) and (8) respectively.

4) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Sections 2008.71(c)(1), (2), (8) and (10) respectively.

5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections 2008.71(c)(1), (2), (8) and (9) respectively.

6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 2008.71(c)(1), (2), (3), (5) and (8) respectively.

7) Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Sections 2008.71(c)(1), (2), (4), (8) and (10) respectively.

8) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this

Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 2008.71(c)(1), (2), (6) and (8) respectively.

9) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 2008.71(c)(1), (2), (5), (6), (8) and (10) respectively.

10) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections 2008.71(c)(1), (2), (3), (5), (7), (8), (9) and (10) respectively.

(Source: Added at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.73 Medicare Select Policies and Certificates

a) This Section shall apply to Medicare Select policies and certificates, as defined in this Section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

b) For the purposes of this Section:

1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, or the use of network providers.

7) "Service area" means the geographic area approved by the Director within which an issuer is authorized to offer a Medicare Select policy.

c) The Director of Insurance may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director finds that the issuer has satisfied all of the requirements of this Part.

d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Director of Insurance.

e) A Medicare Select issuer shall file a proposed plan of operation with the Director of Insurance in a format prescribed by the Director. The plan of operation shall contain at least the following information:

1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

A) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

C) There are written agreements with network providers describing specific responsibilities.

D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2) A statement or map providing a clear description of the service area.

3) A description of the grievance procedure to be utilized.

4) A description of the quality assurance program, including:

A) The formal organizational structure;

B) The written criteria for selection, retention and removal of network providers; and

C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5) A list and description, by specialty, of the network providers.

6) Copies of the written information proposed to be used by the issuer to comply with subsection (i) hereunder.

7) Any other information requested by the Director of Insurance.

f) A Medicare Select issuer shall:

1) File any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing such changes. Such changes shall be considered approved by the Director after thirty (30) days unless specifically disapproved.

2) An updated list of network providers shall be filed with the Director of Insurance at least quarterly.

g) A medicare Select policy or certificate shall not restrict payment for covered services provided by non network providers if:

1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2) It is not reasonable to obtain such services through a network provider.

h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered

services that are not available through network providers.

i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

A) Other Medicare supplement policies or certificates offered by the issuer; and

B) Other Medicare Select policies or certificates.

2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

4) A description of coverage for emergency and urgently needed care and other out of service area coverage.

5) A description of limitations on referrals to restricted network providers and to other providers.

6) A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (i) above and that the applicant

understands the restrictions of the Medicare Select policy or certificate.

k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3) Grievances shall be considered in a timely manner and shall be transmitted to decision-makers who have authority to investigate the issue and take corrective action.

4) If a grievance is found to be valid, corrective action shall be taken promptly.

5) All concerned parties shall be notified about the results of a grievance.

6) The issuer shall report no later than each March 31st to the Director of Insurance regarding its grievance procedure. The report shall be in a format prescribed by the Director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

m) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement

policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six (6) months.

1) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced.

2) For the purposes of this subsection, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for

prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

o) A Medicare Select issuer shall comply with requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

(Source: Added at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.74 Open Enrollment

a) Pursuant to Section 4357 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the requirements of subsection (a) and (b) are effective November 5, 1991. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificates currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

b) Subsection (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before it became effective.

(Source: Added at 16 Ill. Reg. 2766, effective February 11, 1992)

Section ~~2008.71~~ 2008.75 Standards for Claims Payment

a) ~~Every entity providing Medicare supplement policies or contracts~~ An issuer shall comply with ~~all provisions of~~

Section 4081 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (P.L.100-203)), by:

1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

3) Paying the participating physician or supplier directly;

4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

b) Compliance with the requirements set forth in subsSection (a) above must shall be certified on the Medicare supplement insurance experience reporting form.

c) Every insurer, health care plan and other entity providing Medicare supplement insurance shall provide each policyholder, certificate holder, contract holder or enrollee at the time coverage is indicated, a card listing the policy, certificate or contract name and number and a single mailing address to which notices under Section 1842(h)(3)(B) of the Social Security Act (42 U.S.C. 1395 u (h)(3)(B)) respecting coverage are to be sent.

d) As an addition to the Medicare Supplement Insurance Experience reporting form, every insurer, health care service plan or other entity providing Medicare

supplement coverage in this state shall file with the Department a list of its Medicare supplement policy forms, certificates or contracts offered or issued and outstanding in this state as of the end of the previous calendar year.

1) The list shall identify the filing insurer or other entity name address and phone number, shall identify each policy form, certificate or contract by name and form number, and shall differentiate between policy forms, certificates and contracts filed with and approved by the Director in years prior to the previous calendar year, and those filed and approved in the previous calendar year.

2) Policy forms, certificates and contracts which are issued and outstanding in this state but are no longer offered for sale shall be specifically identified, as shall any policy forms, certificates or contracts which, for any reason, were not filed with and approved by the Director.

3) The list shall include identification of any policy form, certificate or contract for which the Director's approval was withdrawn within the previous calendar year.

e) The Director shall, at least annually, provide the Secretary of Health and Human Services with a list containing the information required to be submitted by this section, which has been received by the Director and identifies each insurer, health care plan or other entity by name and address.

(Source: Section 2008.75 renumbered from Section 2008.71 and amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.80 Loss Ratio Standards and Refund or Credit of Premium

a) Pursuant to Section 4355 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508) and Section 363a of P.A. 87-0671 the requirements of this subsection are effective November 5, 1991. A Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, policy

form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form: on the basis of incurred claims experience or incurred health care expenses, as appropriate, and earned premiums for such period and in accordance with accepted actuarial principles and practices:

1) At least 75% of the aggregate amount of premiums earned in the case of group policies; and or

2) At least 60% 65% of the aggregate amount of premiums earned in the case of individual policies and ~~at least 65% of the aggregate amount of premiums earned in the case of sponsored group policies in which coverage is marketed on an individual basis by direct response to eligible individuals in that group only.~~

3) All filings of rates and rating schedules shall demonstrate that ~~actual and expected losses~~ claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

4) ~~Every entity providing Medicare supplement policies in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.~~ For purposes of applying subsection (a) of this Section and Section 2008.81(c)(2), policies issued as a result of solicitations of individuals

through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

~~b) For the purposes of this Section, policy forms shall be deemed to comply with the loss ratio standards if: for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more is greater than or equal to the applicable percentages contained in this Section; and the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this Section. An expected third year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.~~

b) Refund or Credit Calculation

1) An issuer shall collect and file with the Director by May 31 of each year the data contained in Appendix D for each type in a standard Medicare supplement benefit plan.

2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due

shall be made by September 30 following the experience year upon which the refund or credit is based.

c) Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued in this State before or after the effective date of this Part shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director in accordance with the filing requirements and procedures prescribed by the Director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

e)d) As soon as practicable, but prior to the effective date of enhancements in Medicare benefit changes, benefits every ~~insurer, health care service plan or other entity~~ providing issuer of Medicare supplement ~~insurance or contracts~~ policies or certificates in this sState, shall file with the Department:

1) Appropriate premium adjustments necessary to produce loss ratios as ~~originally~~ anticipated for the current premium for the applicable policies or ~~contracts~~ certificates. Such supporting documents as are necessary to justify the adjustment shall accompany the filing; ~~and~~.

2) ~~Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State pursuant to Section 363 of the Code~~ An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or ~~contract~~ certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in

the rates used to produce current premiums by the ~~insurer, health care service plan or other entity~~ issuer for such Medicare supplement ~~insurance~~ policies or ~~contracts~~ certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein ~~should~~ shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

3) If an issuer fails to make premium adjustments acceptable to the Director, the Director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

3)4) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement ~~insurance~~ policy or certificate modifications necessary to eliminate benefit duplications with Medicare. ~~Any~~ sSuch riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or ~~contract~~ certificate.

e) Public Hearings

The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Part if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.81 ~~Filing Requirements for Out of State Group Policies~~ Filing and Approval of Policies and Certificates and Premium Rates

~~Every insurer providing group Medicare supplement insurance benefits to a resident of this State under a master policy issued in another state shall file for informational purposes a~~

~~copy-of-any-certificate-used-in-this-State-together-with-such identification-of-the-group-and-situs-of-the-master-policy-as the-Department-shall-require.--No-insurer-shall-be-required-to make-any-such-informational-filing-earlier-than-30-days-after insurance-was-provided-to-any-resident-of-this-State-under-any such-certificate-(Section-363a(7)-of-the-Code).~~

a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Director.

b) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director.

c) Except as provided in subsection (c)(1), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

1) An issuer may offer, with the approval of the Director, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

A) The inclusion of new or innovative benefits;

B) The addition of either direct response or producer marketing methods;

C) The addition of either guaranteed issue or underwritten coverage;

D) The offering of coverage to individuals eligible for Medicare by reason of disability.

2) For the purposes of this Section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

d) Except as provided in subsection (1) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after the

effective date of this Part that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Director in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director, the issuer shall no longer offer for sale the policy form or certificate form in this State.

2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subsection (1) above, shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period is appropriate.

3) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

4) A change in the rating structure or methodology shall be considered a discontinuance under subsection (d)(1) and (2) unless the issuer complies with the following requirements:

A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change.

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The Director may approve a change to the differential which is in the public interest.

e) Except as provided herein, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 2008.20. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(Source: Section Repealed, New Section adopted at 16 Ill. Reg. 2766 effective February 11, 1992)

Section 2008.82 Permitted Compensation Arrangements

a) An ~~insurer~~ issuer or other entity may provide commission or other compensation to an agent insurance producer ~~or other representative~~ for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for ~~a reasonable number of~~ no fewer than five renewal years.

c) No issuer or other entity shall provide compensation to its ~~agents or other~~ insurance producers and no ~~agent or~~ insurance producer shall receive compensation greater than the renewal compensation payable by the replacing ~~insurer~~ issuer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are greater than the benefits under the replaced policy.

d) For purposes of this sSection, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.90 Required Disclosure Provisions

a) General Rules

1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2) Except for riders or endorsements by which the ~~insurer~~ issuer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with an accompanying increase in premium during the policy term must shall, unless the benefits are required by the minimum standards for Medicare supplement ~~insurance~~ policies, be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

3) A Medicare supplement policyies or certificates which shall not provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import ~~shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage~~.

4) If a Medicare supplement policy or certificate contains any limitations with respect to pre-existing conditions, such limitations must shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

5) Medicare supplement policies ~~or~~ and certificates~~,~~ shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded directly to him or her in a timely manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6) ~~Insurers issuing~~ Issuers of accident and sickness policies~~,~~ or certificates ~~or subscriber contracts~~ which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to ~~all~~ such applicants a "buyer's guide" approved by the Director of Insurance and in type size no smaller than 12 point type. Delivery of the "buyer's guide" shall be made whether or not such policies~~,~~ or certificates~~,~~ ~~or subscriber contracts~~ are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this ~~regulation~~ Part. Except in the case of direct response ~~insurers~~ issuers, delivery of the "buyer's guide" shall be made to the applicant at the time of application and acknowledgement of receipt of the "buyer's guide" shall be obtained by the ~~insurer~~ issuer. Direct response ~~insurers~~ issuers shall ~~deliver~~ the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

b) Policy Checklist.

1) In order to determine what policy is appropriate and nonduplicative, a policy checklist must be completed in the presence of the applicant at the point of sale. Copies of the checklist, completed and duly signed are to be provided to the applicant and the ~~company~~ issuer. This requirement does not apply to direct response solicitations.

2) The checklist required by (b)(1) above shall provide substantially the form prescribed in Appendix A.

3) ~~Insurers~~ Issuers issuing Medicare supplement policies for delivery in this ~~s~~State shall not issue a Medicare supplement policy unless all information requested in the policy checklist is provided.

c) Notice Requirements

1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of Medicare benefit changes, every insurer~~,~~ ~~health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State~~ shall notify its policyholders~~,~~ ~~contract holders~~ and certificate holders of modifications it has made to Medicare supplement insurance policies or ~~contracts~~ certificates in the format prescribed in Appendix E. Such notice shall:

A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement ~~insurance~~ policy or ~~contract~~; certificate, and

B) Inform each ~~covered-person~~ policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. This notice shall be plainly printed in no smaller than twelve (~~11~~2)-point type.

3) Such notices shall not contain or be accompanied by any solicitation.

d) Outline of Coverage Requirements for Medicare Supplement Policies.

1) ~~Insurers issuing Medicare supplement policies for delivery in this state~~ Issuers shall provide an outline of coverage to all applicants at the time the application is ~~made~~ presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

2) If a Medicare supplement policy or certificate is issued on a basis which would require revision of the outline of coverage delivered at the time of application, a substitute outline of coverage properly describing the policy or certificate actually issued ~~must~~ shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

3) In addition to the statement required by Section 2008.90(d)(2) of this Part, each revised outline of coverage accompanying a policy or certificate issued on a basis other than that originally applied for, ~~must~~ shall contain the following notice appearing in no less than twelve (12) point type:

WARNING: The (policy or certificate) you have received is not the same as the one for which you made application.

4) The outline of coverage provided to applicants pursuant to this subsection ~~(d)(2) shall be in the form prescribed in Appendix B~~ shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. Please see Appendix B. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans "A-J"

shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

5) The following items shall be included in the outline of coverage in the order prescribed below. The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

e) Notice Regarding Policies or ~~Subscriber Contracts~~ Certificates Which are Not Medicare Supplement Policies.

In the case wherein a policy, as defined in Section 355(a)(2)(a) of the Code, being sold to a person eligible for Medicare by reason of age provides one or more but not all of the minimum standards for Medicare supplements in Section 363 of the Code, such policy or certificate shall provide notice that such policy is not a Medicare supplement and does not meet the minimum benefits standards set for such policies in this State. Such notice shall appear on the first page of the policy, or certificate ~~or subscriber contract~~ on the first page of the outline of coverage. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS (POLICY, OR CERTIFICATE ~~OR SUBSCRIBER CONTRACT~~) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IT DOES NOT FULLY SUPPLEMENT YOUR FEDERAL MEDICARE HEALTH INSURANCE. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the company."

f) Applications - Notice regarding policies or ~~subscriber contracts~~ certificates which are not Medicare supplement policies.

In the case wherein an application is used to apply for the type of policy as defined in Section 2008.90(e) of

this Part, such application shall provide notice that the policy being applied for is not a "Medicare Supplement" and does not meet the minimum benefits standards set forth for such policies in this State. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) WHICH YOU HAVE APPLIED FOR IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IT DOES NOT FULLY SUPPLEMENT YOUR FEDERAL MEDICARE HEALTH INSURANCE. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the company."

g) Filing Requirements for Advertising

1) ~~Every insurer, health care service plan or other entity providing~~ An issuer of Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Director of Insurance of this State for review by the Director to the extent it may be required under state law.

2) Notice regarding policies or ~~subscriber contracts~~ certificates which are not Medicare supplement policies.

In the case wherein any advertising as defined in Section 2002.40 of 50 Ill. Adm. Code 2002 (Advertising of Accident and Sickness Insurance) is used to solicit the type of policy as defined in Section 2008.90(e) of this Part, such advertising shall provide notice that the policy being advertised is not a Medicare supplement and does not meet the minimum benefits standards set forth for such policies in this State. Such notice shall be prominently disclosed within the text of the advertisement. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IT DOES NOT FULLY SUPPLEMENT YOUR FEDERAL MEDICARE HEALTH INSURANCE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.100 Requirements for Application Forms and Replacement Coverage

a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement ~~insurance~~ or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, ~~except where the coverage is sold without an agent~~ insurance producer, containing such questions and statements may be used.

[STATEMENTS]:

1) You do not need more than one Medicare supplement policy.

2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

4) Counseling services may be available in this State to provide advise concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[QUESTIONS]

To the best of your knowledge,

1) Do you have another Medicare supplement ~~insurance~~ policy or certificate in force (including health care service contract, health maintenance organization contract)?

If so, with which company?

~~2) Did you have another Medicare supplement policy or certificate in force during the last twelve (12) months?~~

~~A) If so, with which company?~~

~~B) If that policy lapsed, when did it lapse?~~

2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

A) If so, with which company?

B) What kind of policy?

~~3~~4) If the answer to question 1 or 2 is yes, ~~Do~~ do you intend to replace ~~any of your~~ these medical or health ~~insurance coverage~~ policies with this policy [certificate]?

~~4~~5) Are you covered by Medicaid?

b) Agents shall list any other health insurance policies they have sold to the applicant.

1) List policies sold which are still in force.

2) List policies sold in the past five (5) years which are no longer in force.

c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be

returned to the applicant by the insurer upon delivery of the policy.

~~c~~d) Upon determining that a sale will involve replacement of Medicare supplement, an ~~insurer~~ issuer, other than a direct response ~~insurer~~ issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the ~~agent, except where the coverage is sold without an agent~~ insurance producer, shall be provided to the applicant and an additional signed copy shall be retained by the ~~insurer~~ issuer. A direct response ~~insurer~~ issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix D.

~~d~~e) The notice required by subsection ~~C~~ D above for an ~~insurer~~ issuer, other than a direct response ~~insurer~~ issuer, shall be provided in the form prescribed in Appendix C in no less than twelve (12) point type.

f) Subsections 1 and 2 of Appendix M (applicable to pre-existing conditions) may be deleted by an issuer if the replacement does not involve application of a new pre-existing condition limitation.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.101 Standards for Marketing

a) ~~Every insurer marketing Medicare supplement insurance coverage in this State,~~ An issuer, directly or through its producers, shall:

1) ~~For purposes of this subsection marketing procedures will be deemed to be fair and accurate if the insurer complies with the standards set forth in Sections 363a(5) and (6) of the Code.~~ Establish fair and accurate marketing procedures which comply with the standards set forth in Sections 363a(5) and (6) of the Code.

2) Establish marketing procedures to assure duplicative insurance benefits are not sold or issued.

~~3) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits greater than the benefits under the replaced policy for purposes of triggering first year commissions as authorized in Section 2008.82 of this Part.~~

43) Display prominently by type, stamp or other appropriate means, on the first page of the ~~outline of~~ coverage and policy the following:

"Notice to buyer: This policy may not cover all of ~~the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations~~ your medical expenses."

54) Inquire of a prospective applicant or enrollee for Medicare supplement insurance whether they are currently covered by accident and sickness insurance and the types and amounts of such insurance.

65) ~~Every insurer or entity marketing Medicare supplement insurance shall e~~Establish auditable procedures for verifying compliance with this subsection Aa.

b) The following acts and practices are prohibited:

1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2) High pressure tactics. Employing any method of marketing having the effect of inducing the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

c) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this Part.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.102 Appropriateness of Recommended Purchase and Excessive Insurance

a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. For purposes of this subsection the insurer will be deemed to make reasonable efforts to determine the appropriateness of the recommended purchase if the insurer complies with the standards set forth in Sections 363a(5) and (6) of the Code.

b) Any sale of Medicare supplement coverage ~~which~~ that will provide an individual more than one Medicare supplement policy or certificate is prohibited~~;~~. ~~provided, however, that additional Medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100% of the individual's actual medical expenses covered under the combined policies.~~

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.103 Reporting of Multiple Policies

a) On or before March 1, ~~every insurer or other entity providing Medicare supplement insurance coverage in this State~~ of each year an issuer shall report the following information prescribed in Appendix F for every individual resident of this State for which the

~~insurer-or-entity~~ issuer has in force more than one Medicare supplement ~~insurance~~ policy or certificate:

1) Policy and certificate number, and

2) Date of issuance.

b) The items set forth above must be grouped by individual policyholder.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.104 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing ~~insurer~~ issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy ~~for similar benefits~~ or certificate to the extent such time was spent under the original policy.

b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008.110 Severability

If any provision of this ~~regulation~~ Part or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of ~~the regulation~~ this Part and the application of such provision to other persons or circumstances shall not be affected thereby.

(Source: Amended at 16 Ill. Reg. 2766 effective February 11, 1992)

Section 2008.APPENDIX A Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE	SUPPLEMENT PAYS	YOU PAY
Hospital Inpatient	First 60 Days	All But ($)			
	61st to 90th Day	All But ($) a Day			
	91st to 150th Day (Lifetime Reserve	($) a Day			
	Beyond 150 Days	Nothing			
Skilled Nursing Home Care	First 20 Days	100% of Cost			
	Additional 80 Days	All But ($) A Day			
	Beyond 100 Days	Nothing			
Medical Expense	Physician's Services in hospital, office or home, in-patient and out-patient medical	80% of Medicare Determined allowable charges after ($) Deductible			

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services and supplies at a hospital, physical and speech therapy and ambulance

Pre-scription Drugs

Inpatient Prescription Drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant.

This policy does/does not comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

DATE _____ SIGNATURE OF APPLICANT _____

SIGNATURE OF AGENT INSURANCE PRODUCER _____

(Source: Amended at 16 Ill. Reg. 2766, effective February 11, 1992)

Section 2008. APPENDIX B Outline of Medicare Supplement Coverage

{COMPANY NAME}
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION

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SECTION 2008. APPENDIX B Outline Of Medicare Supplement Coverage-Cover Page

[COMPANY NAME]
Outline of Medicare Supplement Coverage–Cover Page:
Benefit Plan(s) [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in Illinois.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

(continued)

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F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		Basic Drugs ($1250 Limit)	Basic Drugs ($1250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care

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PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

1) Read-Your-Policy-Carefully----This-outline-of-coverage provides-a-very-brief-description-of-the-important features-of-your-policy.--This-is-not-the-insurance contract-and-only-the-actual-policy-provisions-will control.--The-policy-itself-sets-forth-in-detail-the rights-and-obligations-of-both-you-and-your-insurance company.--It-is,-therefore,-important-that-you-READ YOUR-POLICY-CAREFULLY!

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

2) Medicare-Supplement-Coverage----Policies-of-this-category-are-designed-to-supplement-Medicare-by-covering some-hospital,-medical-and-surgical-services-which-are partially-covered-by-Medicare.--Coverage-is-provided for-hospital-inpatient-charges-and-some-physician charges,-subject-to-any-deductibles-and-copayment provisions-which-may-be-in-addition-to-those-provided by-Medicare,-and-subject-to-other-limitations-which-may be-set-forth-in-the-policy.--The-policy-does-not-provide-benefits-for-custodial-care-such-as-help-in-walking,-getting-in-and-out-of-bed,-eating,-dressing,

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bathing-and-taking-medicine-(delete-if-such-coverage-is provided);

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

3) a) (for agents producers:)

Neither (insert company's name) nor its agents are connected with Medicare.

b) (for direct response:)

(insert company's name) is not connected with Medicare.

4) (A-brief-summary-of-the-major-benefit-gaps-in-Medicare Parts-A-&-B-with-a-parallel-description-of-supplemental benefits,-including-dollar-amounts-and-indexed copayments-or-deductibles,-as-appropriate,-provided-by the-Medicare-supplement-coverage-in-the-following order:)

DESCRIPTION

SERVICE----------PHIS-POLICY-PAYS-----YOU-PAY

PART-A

I.--Minimum-Standards

INPATIENT-HOSPITAL-SERVICES:

Semi-Private-Room-&-Board

Miscellaneous-Hospital-Services &-Supplies,-such-as-Drugs, X-Rays,-Lab-Tests-&-Operating Room

BLOOD

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PART-B

MEDICAL-EXPENSE:

Services-of-a-Physician/ Outpatient-Services

Medical-Supplies-other-than Prescribed-Drugs

Blood

MISCELLANEOUS

Immunosuppressive-Drugs

****

II.--Additional-Benefits

PART-A

Part-A-Deductible

Private-Rooms

In-Hospital-Private-Nurses

Skilled-Nursing-Facility-Care

PARTS-A-&-B

Home-Health-Services

PART-B

Part-B-Deductible

Medical-Charges-in-Excess-of Medicare-Allowable-Expenses (Percentage-Paid)

OUT-OF-POCKET-MAXIMUM

PRESCRIPTION-DRUGS

MISCELLANEOUS

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Respite Care Benefits

Expenses Incurred in Foreign Country

Other

TOTAL PREMIUM----------$---------)

IN ADDITION TO THIS OUTLINE OF COVERAGE, (INSURANCE COMPANY NAME) WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

** If this policy does not provide for coverage for a benefit listed above, the insurer must state "no coverage" beside that benefit in the first column.

(The order of benefits in this outline of coverage should be adjusted by those states which have adopted additional minimum standards.)

5) The following charts shall accompany the outline of coverage:

(Company Name)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE 1990

The following chart briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read this carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format).

MEDICARE PART A

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	In 1990 Medicare Pays Per Calendar Year	Effective January 1, 1990 Medicare Will Pay	In 1990 Your Coverage Pays	Effective January 1, 1990 Your Coverage Will Pay
SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after $500 deductible	All but $592 for first 60 days/ benefit period All but $148 a day for 61st-90th days/ benefit period All but $296 a day for 91st-150th days (6 individual lifetime reserve days)		
Semi-Private Room & Board				
Miscellaneous Hospital Services and Supplies, such as Drugs, X-Rays, Lab Tests and Operating Room				

BLOOD

	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for the benefit	100% of costs for first 20 days (after a 3 day prior hospital confinement) each benefit period
	First 8 days All but $74.00 a day	All but $74.00 a day for 21st 100th days/ benefit period
	8th through 150th day 100% of costs	Beyond 100 days Nothing/benefit period
	Beyond 150 days Nothing	

MEDICARE PART B

SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible)	80% of allowable charges (after $75 deductible/calendar year
PRESCRIPTION DRUGS	Inpatient prescription drugs, 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year	Inpatient prescription drugs, 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/calendar year)
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $75 deductible/calendar year)

(Any other policy benefits not mentioned in the chart should be added to the chart in the order presented by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

This chart summarizing the changes in your Medicare benefits and in your Medicare Supplement provided by (company) only briefly describes such benefits. For a complete list of your Medicare benefits contact your Social Security office or the Health Care Financing Administration. For information on your Medicare Supplement (policy) contact:

(Company or for an individual policy, name of agent, Address/phone number)

6) Statement that the policy does or does not cover the following:

a) Private duty nursing;

b) Skilled nursing home care costs (beyond what is covered by Medicare);

c) Custodial nursing home care costs;

d) Intermediate nursing home care costs;

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e) Home-health-care-above-number-of-visits-covered-by Medicare;

f) Physician-charges-(above-Medicare's-reasonable charges);

g) Drugs-(other-than-prescription-drugs-furnished during-a-hospital-or-skilled-nursing-facility stay);

h) Care-received-outside-the-U.S.A.;

i) Dental-care-or-dentures,-checkups,-routine-immunizations,-cosmetic-surgery,-routine-foot-care, examinations-for-the-cost-of-eyeglasses-or-hearing aids.

7) A-description-of-any-policy-provisions-which-exclude, eliminate,-restrict,-reduce,-limit,-delay-or-in-any other-manner-operate-to-qualify-payments-of-the-benefits-described-in-(4)-above,-including-conspicuous statements;

a) That-the-chart-summarizing-Medicare-benefits-only briefly-describes-such-benefits.

b) That-the-Health-Care-Financing-Administration-or its-Medicare-publications-should-be-consulted-for further-details-and-limitations.

8) A-description-of-policy-provisions-respecting-renewability-or-continuation-of-coverage,-including-any reservation-of-rights-to-change-premium.

9) The-amount-of-premium-for-this-policy.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify

important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Appendix. An issuer may use additional benefit plan designations on these charts pursuant to Section 2008.72(d) of this Part.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director of Insurance.]

(Source: Amended at 16 Ill. Reg. 2766 effective February 11, 1992.

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2008. APPENDIX C, Plan A

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

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MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(Source: Section 2008. APPENDIX C renumbered to Section 2008. APPENDIX M., new Section 2008. APPENDIX C adopted at 16 Ill. Reg. 2766 effective February 11, 1992

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Section 2008 APPENDIX D Notice to Applicant Regarding Replacement of Medicare Supplement Insurance (Direct Response)

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) State law (Section 363(7)(b) of the Illinois Insurance Code, Ill. Rev. Stat. 1989, ch. 73, par. 975) provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best

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interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

2008. APPENDIX D, Plan B

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(Source: Section repealed, new Section adopted at 16 Ill. Reg. 2766 effective February 11, 1992)

2008. APPENDIX E, Plan C

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS–Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL–NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(Source: Section 2008. APPENDIX E renumbered to Section 2008. APPENDIX O, new Section 2008. APPENDIX E adopted at 16 Ill. Reg. 2766 effective February 11, 1992)

2008. APPENDIX F, Plan D

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

MEDICARE (PARTS A & B)–(CONTINUED)

PARTS A & B (cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	$0	$1,600	

OTHER BENEFITS–NOT COVERED BY MEDICARE

FOREIGN TRAVEL–NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(Source: Section repealed at 14 Ill. Reg. 19243, effective November 27, 1990; new Section adopted at 16 Ill. Reg. 2766 effective February 11, 1992.)

2008. APPENDIX G, Plan E

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS–Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL–NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT–NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

(Source: Repealed at 14 Ill. Reg. 19243, effective November 27, 1990; New Section adopted at 16 Ill. Reg. 2766, effective February 11, 1992)

2008. APPENDIX H, Plan F

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 35 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $76.50 a day	Up to $76.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amount*	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS–Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL–NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992.)

2008. APPENDIX I, Plan G

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts*	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

MEDICARE (PARTS A & B)–(CONTINUED)

PARTS A & B (cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	$0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL–NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992.)

2008. APPENDIX J, Plan H

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amount*	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS–Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL–NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS–NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%–$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992.)

2008. APPENDIX K, Plan I

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

MEDICARE (PARTS A & B)–(CONTINUED)

PARTS A & B (cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	$0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL–NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS–NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%–$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992)

2008. APPENDIX L, Plan J

MEDICARE (PART A)–Hospital Services–Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)–Medical Services–Per Calendar Year

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES–IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES–BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

MEDICARE (PARTS A & B)–(CONTINUED)

PARTS A & B (cont'd)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	$0	$1,600	

OTHER BENEFITS

FOREIGN TRAVEL–NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS–NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $5,000 each calendar year	$0	50%–$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

OTHER BENEFITS (cont'd.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services such as fecal occult blood test, rectal exam, mammogram, hearing screening, flu shot, urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992.)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

Section 2008.APPENDIX ~~E~~ M Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Response Other Than Direct)

Insurance company's name and address

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished) you intend to ~~lapse or otherwise~~ terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. ~~For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

You should review this new coverage carefully~~.~~ comparing Compare it with all accident and sickness coverage you now have~~.~~ and ~~t~~Terminate your present policy only if after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

~~STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE): (Use additional sheets, as necessary.)~~ INSURANCE PRODUCER:

I have reviewed your current medical or health insurance coverage. ~~I believe t~~The replacement of insurance involved in this transaction ~~materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:~~ does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (Check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify) _____

1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new

policy, whereas a similar claim might have been payable under your present policy.

2) State law (Section 363(7)(b) of the Illinois Insurance Code, Ill. Rev. Stat. ~~1989~~ 1990 Supp., ch. 73, par. 975) provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The ~~insurer~~ issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

~~3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

4) If, ~~after due consideration,~~ you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/ and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, ~~reread~~ review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of ~~Agent, Broker~~ Insurance Producer or Other Representative)

Typed Name and Address of ~~Agent or Broker~~ Issuer or Insurance Producer

~~The above "Notice to Applicant" was delivered to me on:~~

_____
~~Date~~

_____
(Applicant's Signature)

_____
Date

(Source: Section 2008.APPENDIX M renumbered from Section 2008.APPENDIX C and amended at 16 Ill. Reg. 2766, effective February 11, 1992)

SECTION 2008. APPENDIX N. Medicare Supplement Refund Calculation Format

For Calendar Year _____

Type _____ SMSBP (w) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing this Form _____

Title _____ Telephone Number _____

Line		(a) Earned Premium (x)	(b) Incurred Claims (y)
1.	Current Year's Experience		
	a. Total (all policy years)	_____	_____
	b. Current year's issues (z)	_____	_____
	c. Net (for reporting purposes = 1a – 1b)	_____	_____
2.	Past Year's Experience (all policy years)	_____	_____
3.	Total Experience (net current year + past year's experience)	_____	_____
4.	Refunds last year (excluding interest)	_____	
5.	Previous since Inception (excluding interest)	_____	
6.	Refunds since Inception (excluding interest)	_____	
7.	Benchmark Ratio since Inception (see worksheet for Ratio 1)	_____	
8.	Experienced Ratio since Inception		

Total Actual Incurred Claims (line 3, col. b) / Total Premium After Refunds = Ratio 2

Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6)

9. Life Years Exposed Since Inception
If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted _____
(obtained from credibility table)

11. Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance _____

If ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If ratio 3 is less than the benchmark ratio, then proceed.

12. Adjusted Incurred Claims = Total Earned Premium (line 3, col. a) – Refunds since Inception (line 6) x Ratio 3 (line 11). _____

13. Refund = Total Earned Premium after Refunds – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)] _____

Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%

If less than 500, no credibility.

(w) "SMSBP" = Standard Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged
(y) Excludes Active Life Reserves
(z) This is to be used as "Issue Year Earned Premium" for 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____ _____
Signature Title

_____ _____
Name–please type Date

WORKSHEET FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
For Calendar Year _____

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m):

(a): Year 1 is the current calendar year–1
Year 2 is the current calendar year–2 (etc.)
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

WORKSHEET FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
For Calendar Year _____

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m):

(a): Year 1 is the current calendar year–1
Year 2 is the current calendar year–2 (etc.)
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

(Source: Added at 16 Ill. Reg. 2766, effective February 11, 1992)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

SECTION 2008. APPENDIX ~~E~~O. NOTICE ON MEDICARE CHANGES~~–1990~~

(Company Name)

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE~~–1990~~

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format).

Services	**Medicare Benefits**		**Your Medicare Supplement Coverage**	
	~~In 1989 Medicare Pays Per Calendar Year~~	Effective (insert current calendar year) ~~January 1, 1989~~ Medicare Will Pay	~~In 1989 Your Coverage Pays~~	Effective (insert current calendar year) ~~January 1, 1989~~ Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	~~Unlimited number of hospital days after $560 deductible~~	All but ~~$592~~ _____ for first 60 days/ benefit period		
Semi-Private Room & Board		All but ~~$148~~ _____ a day for 61st-90th days/ benefit period		
Miscellaneous Hospital Services and Supplies such as Drugs, X-Rays, Lab Tests and Operating Room		All but ~~$296~~ _____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	~~Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B~~	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each calendar year		
SKILLED NURSING FACILITY CARE	~~There is no prior confinement requirement for the benefit~~	100% of costs for first ~~30~~ 20 days (after a 3 day prior hospital confinement/benefit period		
	~~First 8 days– All but $26.50 a day~~	All but ~~$74.00~~ _____ a day for 21st-100th days/ benefit period		
	~~9th through 150th day– 100% of costs~~	Beyond 100 days– Nothing/benefit period		
	~~Beyond 150 days– Nothing~~			

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

Services	**Medicare Benefits**		**Your Medicare Supplement Coverage**	
	~~In 1989 Medicare Pays Per Calendar Year~~	Effective (insert current calendar year) ~~January 1, 1989~~ Medicare Will Pay	~~In 1989 Your Coverage Pays~~	Effective (insert current calendar year) ~~January 1, 1989~~ Your Coverage Will Pay
MEDICARE PART B SERVICES & SUPPLIES	~~80% of allowable charges (after $75 deductible)~~	80% of allowable charges (after $75 _____ deductible/ calendar year)		
PRESCRIPTION DRUGS	~~Inpatient prescription drugs 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 _____ deductible/ calendar year)~~	Inpatient prescription drugs 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 _____ deductible/calendar year)		
BLOOD	~~80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/ calendar year)~~	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $75 _____ deductible/calendar year)		

(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY) CONTACT: (COMPANY AND FOR AN INDIVIDUAL POLICY–NAME OF AGENT); (ADDRESS/PHONE NUMBER)

(Source: Section 2008. APPENDIX O renumbered from Section 2008. APPENDIX E and amended at 16 Ill. Reg. 2766, effective February 11, 1992)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

SECTION 2008. APPENDIX P. MEDICARE SUPPLEMENT POLICIES REPORT

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this report is to provide information on each resident of this State who has more than one Medicare supplement policy or certificate in force. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

(Source: Added at 16 Ill. Reg. 2766 effective February 11, 1992.)

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED REPEALER

1) The Heading of the Part: Management of Scrap Tires

2) Code Citation: 35 Ill. Adm. Code 849

3)

Section Number:	Adopted Action:
849.101	Repeal
849.102	Repeal
849.103	Repeal
849.104	Repeal
849.105	Repeal
849.106	Repeal

4) Statutory Authority: Ill. Rev. Stat. 1989, ch. 111 1/2, pars. 1027 and 1055.2.

5) Effective Date of Amendments: February 11, 1992

6) Does this rulemaking contain an automatic repeal date?: No.

7) Does this amendment contain incorporations by reference?

No.

8) Date Filed in Agency's Principal Office: February 6, 1992.

9) Notice(s) of Proposal Published in Illinois Register: 15 Ill. Reg. 13265 (September 13, 1991).

10) Has JCAR issued a Statement of Objections to this (these) Rule(s)?

No.

11) Difference(s) between proposal and final version: None.

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreement letter issued by JCAR?

None requested.

13) Will this rule (amendments, repealer) replace an emergency rule currently in effect? No.

14) Are there any amendments pending on this Part? No.

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED REPEALER

15) Summary and Purpose of Rule(s):

A complete description is contained in the Board's Opinion of February 6, 1992 in 90-9(B), which Opinion is available from the address below.

This rulemaking repeals certain management standards for scrap tires. New management standards for used and waste tires were adopted by the Board on April 25, 1991 in R90-9A.

16) Information and questions regarding this adopted amendment shall be directed to:

Mark P. Miller
Illinois Pollution Control Board
104 W. University
Urbana, IL 61801
217/ 333-5575

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF ADOPTED RULES

1) Heading of the Part: Illinois Children's School and Rehabilitation Center's Respite Program

2) Code Citation: 89 Ill. Adm. Code 787

3)

Section Numbers:	Adopted Action:
787.10	New Section
787.20	New Section
787.30	New Section
787.40	New Section
787.50	New Section

4) Statutory Authority: Sections 3 and 11 of the "Disabled Persons Rehabilitation Act" (Ill. Rev. Stat. 1990 Supp., ch. 23, pars. 3429, 3434 and 3442).

5) Effective Date of Rule(s) (Amendments, Repealer): February 11, 1992

6) Does this rulemaking contain an automatic repeal date?
___ Yes _X_ No

7) Does this rule (amendment, repealer) contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: February 11, 1992

9) Notice of Proposal Published in Illinois Register:

___September 6, 1991___, __15__Ill. Reg.__13027_____
(issue date)

10) Has JCAR Issued a Statement of Objections to this (these) Rule(s)? no If answer is "yes," please complete the following:

A) Statement of Objection: _____, ___Ill. Reg.____
(issue date)

B) Agency Response: _____, ___Ill. Reg._____
(issue date)

C) Date Agency Response Submitted for Approval to JCAR:

11) Difference(s) between proposal and final version: none

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR?
Yes

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF ADOPTED RULES

13) Will this rule replace an Emergency Rule(s) currently in effect? No

14) Are there any amendments pending on this Part: No

Section Numbers	Proposed Action	Illinois Register Citation

15) Summary and Purpose of Rule(s): This rule implements the Illinois Children's School and Rehabilitation Center's Respite Program

16) Information and answers to questions regarding this adopted rule shall be directed to:

Ms. Susan Warrner, Acting Manager
Regulations and Procedures Division
Department of Rehabilitation Services
P.O. Box 19429
Springfield, Illinois 62794-9429

Telephone number: (217) 785-3896
T.D.D.: (217) 785-9301

The full text of Adopted Rule(s) begins on the next page:

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF ADOPTED RULES

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF REHABILITATION SERVICES
SUBCHAPTER f: EDUCATIONAL FACILITIES

PART 787
ILLINOIS CHILDREN'S SCHOOL AND REHABILITATION CENTER'S RESPITE PROGRAM

Section
787.10 Description of Respite Program
787.20 Eligibility for Respite Program
787.30 Referral and Application
787.40 Termination of Services
787.50 Appeals

AUTHORITY: Implementing and authorized by Sections 3 and 11 of the "Disabled Persons Rehabilitation Act" (Ill. Rev. Stat. 1990 Supp., ch. 23, pars. 3434 and 3442).

SOURCE: Adopted at 16 Ill. Reg. 2882, effective February 11, 1992.

Section 787.10 Description of Respite Program

a) The Department of Rehabilitation Services (DORS) provides family oriented respite care, tailored to the unique and specific needs of individual families, at the Illinois Children's School and Rehabilitation Center (ICSRC) in Chicago. Respite is defined, for this program, as short term, intermittent day or overnight care for children with disabilities.

b) The services provided in the respite program are the following:

1) medical supervision by a licensed physician;
2) nursing care;
3) dietary care as ordered by ICSRC's physician;
4) recreation;
5) activities of daily living (including bathing, dressing, meals);
6) physical or occupational therapy as prescribed by ICSRC's physician; and
7) educational services as described in the Individualized Educational Program (IEP) (if the length of stay is for 10 or more days).

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c) Emergency medical care and repair/maintenance of personal equipment (e.g., braces, wheelchairs) are the responsibility of, and must be paid for by, the family.

d) Respite care shall be available only when ICSRC is in session.

e) Up to 30 days of overnight care per 12 month period shall be provided to any single child. Daytime care is limited to four calendar days per month per child, unless additional space is available in the program.

Section 787.20 Eligibility for Respite Program

a) To be eligible for the respite program at ICSRC, a child shall:

1) be a resident of Illinois;
2) have a physical disability or health impairment;
3) be between the ages of 5 and 21;
4) be medically stable and not in the last stages of a progressive disability/illness as verified by a physician's statement;
5) have tested negative for tuberculosis within the past 6 months;
6) have a record of updated vaccinations;
7) have a signed release for emergency medical care;
8) have a University of Illinois Clinic Card; and
9) meet all the eligibility requirments for students admitted to ICSRC (89 Ill. Adm. Code 755.20).

b) Eligible children will be served in the following priority order:

1) children in need of care due to the loss of a primary caregiver because of hospitalization or death, or other family crisis;
2) children from families with more than one child with a disability; and
3) children from families who are absent from the home because of vacation, etc.

Section 787.30 Referral and Application

a) Referrals can be made by parents, social service agencies, schools, hospitals, child care agencies, medical personnel or any other person or agency that is interested in the welfare of the child.

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b) Any individual, family or agency applying for respite care for a child shall be referred to ICSRC's social work staff who will assess the needs of the family and of the child based on the services that the Respite Program offers, the availability of a bed (if necessary), and the identification of any factors, such as family stresses, which increase the risk for child abuse or neglect if the child remains in his/her present environment. The ICSRC Physician and the Nursing Supervisor will assess the medical status of the child. The social work assessment and medical assessment will be given to the ICSRC's Respite Admission Committee.

c) An individual, family or agency applying for respite care for a child shall submit the following information:

1) Respite Care Application (IL 488-2092);
2) Medical History (IL 488-2099);
3) Daily Care Plan (required unless emergency care is provided) (IL 488-2096);
4) Insurance Information (IL 488-2097);
5) Length of Stay Agreement (IL 488-2098);
6) Medical Consent Form (IL 488-2093);
7) Emergency Treatment Consent (IL 488-2094);
8) Permission for trips and visits (IL 488-0876);
9) Photo and swim consent (IL 488-2095); and
10) University of Illinois Clinic Card Application.

d) The following shall be submitted to the facility administrator of ICSRC in addition to the forms cited above at the time of application if the child is anticipated to stay in the respite program for at least 10 consecutive days:

1) a copy of the child's most recent Multidisciplinary Conference and IEP developed by the district of parental/student residence; and

2) the child's most recent case study evaluation including all components as required by 23 Ill. Adm. Code 226.535. If the evaluation is more than three years old, ICSRC will make arrangements for a case study evaluation to be conducted prior to the child being admitted to the respite program.

e) When the child is enrolled in the ICSRC respite program for 10 or more consecutive days, the rules in 89 Ill. Adm. Code Subchapter f will apply with respect to the provision of educational services.

f) Notification of the disposition of the application will be made within 10 school days of the date of receipt of the application by ICSRC's Respite Admission Committee. The decision of eligibility is based upon the criteria in Section 787.20. The Committee is composed of the following personnel, or their designees:

1) Assistant Center Administrator for Transitional Services;
2) Social Services Supervisor;
3) Nursing Supervisor; and
4) ICSRC Physician.

Section 787.40 Termination of Services

Services may be terminated at the discretion of the family or ICSRC when the activities provided in Section 787.10(b) are no longer required and/or the eligibility criteria in Section 787.20 no longer are met. When services are terminated, the family will be referred to other, more appropriate long term services.

Section 787.50 Appeals

a) Definitions. For the purpose of this Section, the following terms have the following meanings:

1) "Days", unless otherwise specified, means school days, i.e., Mondays through Fridays, excluding State established holidays or days on which State government offices are closed by order of the Governor.

2) "Director" means the Director of DORS.

3) "Grievant" means any person who has been aggrieved by any action of the ICSRC or DORS pursuant to this Part; any person who has been denied services of the ICSRC Respite Program; or the parent or guardian of a minor who qualifies as a "Grievant".

b) General Information

1) Any and all notices and communications made pursuant to this Section shall be in writing, unless the grievant is unable to communicate in writing. All nonwritten communications must be documented in the grievant's file.

2) A personal representative may exercise any right of the grievant on the grievant's behalf. A grievant may only designate one personal representative at any one time.

3) All time periods related to communications arising under this Section commence on the date of receipt for mailed items (receipt is presumed 4 days from the date of postmark); or on the day of delivery for hand delivered items; or on the date of receipt of a nonwritten communication.

4) Appeals by any party not a grievant cannot be heard by DORS pursuant to this Section.

c) What May Be Appealed

The following may be appealed under this Section:

1) a determination that a child is ineligible for services; and

2) termination of services.

d) Grievant Rights

1) DORS shall make the grievant aware, in a language that is understandable to the grievant, of the right to appeal pursuant to this Section, at the following times or events:

A) upon denial of services; and

B) upon termination of services.

2) A Level 1 hearing is optional. The grievant has the right to request that the grievance proceed to Level II, which hearing shall be scheduled within 2 days after the client's request.

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3) The grievant may request an interpreter within 2 days after being informed of his/her rights, either sign (if the grievant is hearing impaired) or language (if the grievant's normally spoken language is other than English), to attend the hearing. A visually impaired grievant may either request a reader to read materials provided by DORS in preparation for the hearing or request that the materials be provided in Braille, large print or audiotape.

4) All meetings with the grievant pursuant to this Section must occur at a time and location convenient to both parties.

5) All proceedings pursuant to this Section are to be confidential and not open to the general public unless requested to be so by the grievant.

6) After a request for a hearing is received by DORS, the grievant will be provided with written notification of his/her right to:

A) review the case file and other related documents;

B) be represented by a personal representative who has filed an appearance with DORS pursuant to Section 787.50(b)(2);

C) an explanation of the appeal process as set forth in this Section;

D) request an interpreter pursuant to subsection (d)(3) of this Section;

E) decline to appear for a Level I or II hearing, in which case the case file and any new evidence or information submitted by the grievant shall be reviewed and a decision made based on that review by the Hearing Officer;

F) withdraw the appeal at any time during the process, in which case the grievant cannot request a reopening of the appeal;

G) a timely and impartial hearing;

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H) confidentiality of these proceedings, as set forth in 89 Ill. Adm. Code 505.10 and pursuant to subsection (d)(5) above; and

I) have DORS employees involved in the appealed action present at the hearing, and to question them.

e) DORS' Rights

DORS has the right to:

1) have a DORS attorney present at any hearing;

2) cooperation by the grievant;

3) publish hearing summaries, with deletions as necessary to ensure confidentiality; and

4) consolidate for hearing all issues relating to a grievant or to several grievants which arise out of the same set of facts and circumstances.

f) Conduct of Level I and Level II Hearings

All hearings, as set forth in this Part, shall be conducted in the following manner:

1) DORS employees directly involved in the contested action shall be present to testify and can be questioned by the grievant. However, if such person is no longer employed by DORS and declines to attend the hearing after DORS has made a reasonable attempt to secure his/her attendance, the person most knowledgeable about the case shall attend;

2) a hearing shall not be adjourned until the Hearing Officer has received all information agreed upon, within the time the parties have agreed to provide it;

3) only information directly related to the issue under review, per Section 787.50(b), shall be introduced from the grievant's case file. The Hearing Officer shall not consider any information that has not been made available to the other party;

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4) either party may present additional information and evidence, which must also be made available to the other party;

5) if the grievant has chosen to have a Level I hearing and then requests a Level II hearing, the Level II hearing shall review only those issues presented by the grievant in the Level I hearing or which are material and related to those presented in the Level I hearing;

6) the following is the order of proceedings:

   A) presentation, argument and disposition of all preliminary motions and matters,

   B) opening statements,

   C) evidence presented by the grievant,

   D) evidence presented by DORS,

   E) rebuttal by either or both sides, and

   F) closing statements.

7) The grievant and DORS shall call any person as a witness and conduct examinations and cross-examinations. The Hearing Officer may examine any witness at any time or request additional information from either party.

8) The grievant and DORS shall, by stipulation, agree upon any facts or laws involved in the proceeding. The facts stipulated shall be considered as evidence in the proceeding.

9) It is the grievant's responsibility to prove to the Hearing Officer that his/her position is correct, and the grievant shall be so informed prior to the Level I and Level II hearings.

10) DORS shall assume all administrative costs of the appeals, i.e., interpreter, pursuant to Section 787.50(c)(2), and record, pursuant to Section 787.50(h)(4), but not costs personally incurred by the grievant because of the proceedings, e.g.,

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legal fees, travel, witness costs, and room and board.

11) All parties involved in the hearing shall avoid continuances so that the subject matter of the hearing may be resolved expeditiously. A hearing shall for good cause shown (e.g., illness of the grievant, representative, or DORS employee or severe weather problems) be continued once by the Hearing Officer. Notice of the request shall be given in writing to the other party and to the Hearing Officer no less than one (1) day prior to the previously scheduled hearing date, in the absence of an emergency.

12) DORS and the Hearing Officer shall be notified by the grievant of the appointment of a personal representative by filing, no later than 1 day in advance of a hearing, a notice of appearance stating the personal representative's name, address and telephone number, identifying the grievant represented, and signed by the grievant. Such notice shall be accompanied by appropriate consent for the release of confidential information to the personal representative.

13) At least 1 day prior to the hearing, the grievant and the DORS staff person who has taken the action being appealed shall provide each other and the Hearing Officer with a list of witnesses, copies of documents not in the possession of the other party, and a summary of the evidence that they plan to present at the hearing.

14) The Hearing Officer has the power to:

   A) control the conduct of the hearing to prevent irrelevant or immaterial discussion (repetitive discussion or discussion not germane to the issue being appealed);

   B) rule upon all motions and other matters arising in the course of the hearing, including, but not limited to, a party's motion or objection concerning the admissibility of evidence; and

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C) require the parties, at any stage of any hearing or after all parties have completed the presentation of their evidence, to present further evidence including, but not limited to, the production of any and all documents, books, papers and accounts the Hearing Officer deems material or relevant to any issue.

15) Any relevant evidence presented which is of a type commonly relied upon by reasonably prudent individuals shall be admitted, i.e., any information not presented in the Level I hearing previously which pertains to the issues raised in the appeal and has been made available to both parties within the agreed upon time.

g) Level I Hearings

1) The request for a Level I hearing shall be received within 2 days after receipt of the written notice.

2) The Hearing Officer for a Level I hearing shall be the supervisor of the DORS staff person who has taken the action being appealed, or that person's supervisor.

3) The hearing shall be scheduled 3 to 5 days after the date of receipt of request for hearing. The grievant must be informed by the Hearing Officer, within 2 days after receiving the request, of the date, time, location of the hearing, name and address of the Hearing Officer (for requests for extensions), and of all rights accorded under this Section.

4) Within 2 days after adjournment of the Level I hearing, the Hearing Officer shall attempt to inform the grievant, by telephone, of the decision, with written confirmation received by the grievant within 7 days.

The decision must contain:

A) a statement of the basis upon which the decision was made;

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B) the applicable laws and policies used;

C) the name and address of the DORS Hearings Coordinator; and

D) a statement that if the grievant is dissatisfied with the decision, a request for a Level II hearing must be received by the Hearings Coordinator within 5 days from the date of receipt of the Level I hearing decision notice.

h) Level II Hearings

1) If the grievant is not satisfied with the the Level I decision or requests to bypass the Level I hearing and proceed with the Level II hearing, he/she may request a Level II hearing. The request shall be received within 5 days from the date of receipt of the written Level I hearing decision, and propose an acceptable date for the hearing, which date shall be within 5 days after the request.

2) Within 1 day after receipt of the request for a Level II hearing, the DORS Hearings Coordinator shall send the grievant a letter acknowledging the request for a hearing, selecting a date, affirming the location of the hearing, stating the Hearing Officer's name and address and informing the grievant of all rights accorded pursuant to this Section.

3) The hearing shall be heard by an Impartial Hearing Officer selected by the Hearings Coordinator from the list maintained by him/her.

4) DORS shall make an audio tape recording of the proceedings and will provide one copy to the grievant upon request, at no cost. Upon request by a visually impaired grievant, one copy of either a Braille or large print transcript will be provided at no cost.

5) The testimony and exhibits constitute the official record of the hearing.

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6) Findings of fact and the decision prepared by the Hearing Officer will be mailed within 1 day after the adjournment of the hearing. The decision shall state the principal issues and relevant facts brought out at the hearing, the pertinent provisions in law and DORS policy, the reasoning that led to the decision, the provisions for the Director's Review as set forth in Section 787.70(i), and any appeal rights or procedures that may be available. This decision shall be sent by certified mail, return receipt requested, to the grievant. A copy of the decision will also be sent to the Director and the grievant's representative, if any.

i) Director's Review

1) The Director may choose to review any Level II decision by issuing a Notice of Intent to Review within 7 days after the receipt by the grievant of the finding of the Level II Hearing Officer. The Notice shall be mailed to the grievant. The scope of such review shall include, but is not limited to, the consistency of the Hearing Officer's findings with applicable law and regulations.

2) If the Director determines that a review is necessary, based on the rationale of the findings of fact and the decision of the Hearing Officer, a Notice shall be sent to the grievant, who shall be informed of the right to submit additional written evidence and arguments to the Director, which shall be received within 7 days after receipt of the Notice.

3) The DORS Hearings Coordinator and appropriate program staff shall review the grievant's case file and the transcript of the Level II hearing, and make a recommendation to the Director regarding a Level II decision which is thought to be:

A) in violation of constitutional, statutory or regulatory provisions, or written policy;

B) in excess of the statutory authority of DORS;

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C) affected by other error of law, regulation, or written policy;

D) not reasonably supported by the evidence; or

E) arbitrary, capricious, or characterized by abuse of or clearly unwarranted exercise of discretion.

4) The Director may modify, reverse or uphold the Hearing Officer's decision. This decision is based upon review of the Level I decision, the Level II record, and the Hearing Officer's decision, and any additional evidence and arguments submitted by the grievant.

5) The Director's decision, citing the findings and grounds, shall be sent within 12 days after the Notice by certified mail, return receipt requested.

6) DORS administrative action becomes final upon the decision of the Director, or if no such review has been undertaken, 10 days after the Level II Hearing Officer's decision has been issued.

7) Any further appeal shall be made to the courts.

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of Part: Abandoned Mined Lands Reclamation Council

2) Code Citation: 62 Ill. Adm. Code 2501

3) Section Number: Emergency Action

2501.37 New Section

4) Statutory Authority:

Ill. Rev. Stat. 1989, ch. 96½, par. 8003.01

5) Effective Date of Rules:

February 4, 1992

6) If this emergency rule is to expire before the end of the 150-day period, please specify date on which it is to expire.

Not applicable. The emergency section will not expire before the end of the 150-day period.

7) Date filed in Agency's Principal Office:

February 4, 1992

8) Reason for Emergency:

The emergency amendments will implement in a timely manner P.A. 87-379, which became law on September 9, 1991.

9) A complete description of the subjects and issues involved:

P.A. 87-379 which became law on September 9, 1991 added a new Section 2.12 to the Abandoned Mined Lands and Water Reclamation Act. The statute requires the Abandoned Mined Lands Reclamation Council to file a Notice of Reclamation, following reclamation activities, in the office of the Recorder in the county in which the reclaimed land lies. The proposed amendments will implement P.A. 87-379.

10) Are there any other proposed amendments pending on this part?

No. (The text of the emergency amendments appears as proposed amendments in this issue of the Illinois Register.)

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF EMERGENCY AMENDMENTS

11) Statement of Statewide Policy Objectives:

Not applicable. This rulemaking does not create or expand a State mandate on units of local government, school districts, or community college districts.

12) Information and questions regarding this rule shall be directed to:

Kevin H. Kahl, Legal Counsel
Abandoned Mined Lands Reclamation Council
928 South Spring Street
Springfield, Illinois 62703
217/782-0588

The full text of the Emergency Amendments begins on the next page:

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF EMERGENCY AMENDMENTS

TITLE 62: MINING
CHAPTER II: ABANDONED MINED LANDS RECLAMATION COUNCIL

PART 2501
ABANDONED MINED LANDS RECLAMATION

Section
2501.1 Scope
2501.4 Definitions
2501.7 Objectives and Priorities
2501.10 Eligible Lands and Water
2501.13 Project Selection
2501.16 Project Deferment
2501.19 Annual Grant Process
2501.22 Reclamation Activities
2501.25 Reclamation on Private Lands
2501.28 Rights of Entry
2501.31 Land Acquisition, Management and Disposal
2501.34 Emergency Abatement Activities
2501.37 ~~Advisory Committee (Repealed)~~ Notice of Reclamation
EMERGENCY
2501.40 Public Participation (Repealed)

AUTHORITY: Implementing and authorized by the Abandoned Mined Lands and Water Reclamation Act (Ill. Rev. Stat. 1989, ch. 96½, pars. 8001.01 et seq.).

Source: Adopted and codified at 5 Ill. Reg. 9740, effective October 1, 1981; recodified at 8 Ill. Reg. 7212; amended at 9 Ill. Reg. 6641, effective May 1, 1985; emergency amendment at 10 Ill. Reg. 1254, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 14271, effective August 14, 1986; amended at 15 Ill. Reg. 6513, effective May 3, 1991; emergency amendment at 16 Ill. Reg. 2897, effective February 4, 1992 for a maximum of 150 days.

Section 2501.37 Notice of Reclamation
EMERGENCY

a) FOLLOWING RECLAMATION, THE COUNCIL SHALL FILE A NOTICE OF RECLAMATION IN THE OFFICE OF THE RECORDER IN THE COUNTY IN WHICH THE RECLAIMED LAND LIES. THE NOTICE OF RECLAMATION SHALL IDENTIFY THE LAND RECLAIMED, THE ADVERSE EFFECTS OF PAST MINING ON THE LAND, AND BRIEFLY DESCRIBE THE RECLAMATION. THE NOTICE OF RECLAMATION SHALL SERVE AS PERPETUAL NOTICE TO ALL CONCERNED THAT THE LAND HAS BEEN MINED AND RECLAIMED, AND PROVIDE THAT FURTHER INFORMATION MAY BE OBTAINED BY CONTACTING THE COUNCIL; (P.A. 87-379).

ABANDONED MINED LANDS RECLAMATION COUNCIL

NOTICE OF EMERGENCY AMENDMENTS

b) A Notice of Reclamation shall be filed only with respect to land that has been adversely effected with the physical impacts of mining, and will continue after reclamation to contain such physical effects even though reclaimed, including:

1) mine shafts, slope entries, or other mine openings

2) coal refuse and tailings

3) mine gas escape points

4) hazardous equipment or facilities

5) dangerous highwalls or embankments

6) spoil

7) acid water impoundments

8) dangerous impoundments or dam structures

9) subsidence pits or troughs

c) A Notice of Reclamation shall not be filed in connection with land that is affected by reclamation activities only to provide ingress and egress, mobilization or staging areas, borrow or cover material, or other support activities.

d) A Notice of Reclamation shall not be filed where all adverse effects, physical impacts, or remnants thereof are removed from the property by the reclamation.

(Source: Section repealed; new section adopted by emergency action at 16 Ill. Reg. 2897, effective February 4, 1992 for a maximum of 150 days.)

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NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Community Care Program

2) Code Citation: 89 Ill. Adm. Code 240

3) Section Numbers: 240.720 Emergency Action: Amendment
240.725 Amendment
240.800 Amendment
240.810 Amendment
240.825 Amendment
240.855 Amendment

4) Statutory Authority: Ill. Rev. Stat., 1989, Ch. 23 Sections 6104.01(4), (9), (11) and (12); 6104.02, 6104.03 and 6105.02

5) Effective Date of Amendment(s): February 6, 1992

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: June 30, 1992.

7) Date Filed in Agency's Principal Office: February 6, 1992

8) Reason for Emergency:

Pursuant to the Emergency Budget Act of Fiscal Year 1992, the General Assembly has found that the State's "current financial situation constitutes an emergency" and thereby authorizes the Department "to limit services, to reduce or adjust payment rates, and to modify eligibility criteria as necessary to implement contingency reserves" (P.A. 87-838, 87th General Assembly, Special Session, January, 1992) in order to balance the State's FY92 budget.

As a result of the above, it is necessary for the Department to eliminate the "grandfathered" status of Community Care Program (CCP) clients and to require all clients to meet current eligibility requirements and to share in the cost of their care as soon as possible. Therefore, emergency amendments delineating the elimination of the "grandfathered" status and providing the means whereby all Community Care Program clients are required to meet current eligibility requirements and to share in the cost of their care have been adopted by means of the Emergency Rulemaking process.

With these emergency changes, the Department on Aging will be able to eliminate the "grandfathered" status for Community

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Care Program clients and to require all CCP clients to meet current eligibility requirements and to share in the cost of their care to ensure that the resources of the Community Care Program are targeted appropriately and that all elderly requiring service will receive care.

9) A Complete Description of the Subjects and Issues Involved:

Effective February 6, 1992, and ending July 1, 1992, those agencies which provide in-home services (chore-housekeeper and homemaker) under the Community Care Program will begin to eliminate the "grandfathered" status of Community Care Program clients and to require all CCP clients to meet current eligibility requirements and to share in the cost of their care. All agencies which provide in-home services (chore-housekeeping and homemaker) and are affected by this emergency rulemaking.

This emergency rulemaking allows the Department to eliminate the "grandfathered" status of Community Care Program clients and to require all CCP clients to meet current eligibility requirements and to share in the cost of their care, thereby ensuring that the limited resources of the program are distributed equitably and distributed most specifically to those elderly in the greatest economic and social need.

10) Are there any proposed amendments pending on this Part? Yes.

Section Numbers	Proposed Action	Illinois Register Citation
240.655	Amendment	10/11/91:15 Ill.Reg. 14335
240.430	Amendment	12/02/91:15 Ill.Reg. 17007
240.435	Amendment	12/02/91:15 Ill.Reg. 17007
240.720	Amendment	12/02/91:15 Ill.Reg. 17007
240.725	Amendment	12/02/91:15 Ill.Reg. 17007

11) Statement of Statewide Policy Objectives: Not applicable.

12) Information and questions regarding this amendment shall be directed to:

Name: Mary J. Mayes
Policy and Rules Analyst
Address: Illinois Department on Aging
421 East Capitol Avenue
Springfield, IL 62701
Telephone: (217) 785-3357

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

The full text of the Emergency Amendment(s) begins on the next page:

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 240
COMMUNITY CARE PROGRAM

SUBPART A: GENERAL PROGRAM PROVISIONS

SUBPART B: SERVICE DEFINITIONS

SUBPART C: RIGHTS AND RESPONSIBILITIES

SUBPART D: APPEALS

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SUBPART E: APPLICATION

SUBPART F: ELIGIBILITY

SUBPART G: NON-FINANCIAL REQUIREMENTS

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SUBPART H: FINANCIAL REQUIREMENTS

SUBPART I: DISPOSITION OF DETERMINATION

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SUBPART J: SPECIAL SERVICES

SUBPART K: TRANSFERS

SUBPART L: ADMINISTRATIVE SERVICE CONTRACT

SUBPART M: CASE COORDINATION UNITS AND VENDORS

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SUBPART N: CASE COORDINATION UNITS

SUBPART O: VENDORS

SUBPART P: VENDOR PROCUREMENT

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SUBPART R: ADVISORY COMMITTEES

Section
240.1800 Policy Advisory Committee
240.1850 Technical Rate Review Advisory Committee

SUBPART S: VENDOR RATES

Section
240.1910 Establishment of Fixed Unit Rates
240.1920 Contract Specific Variations
240.1930 Fixed Unit Rates of Reimbursement for Chore-Housekeeping and Homemaker Services
240.1940 Fixed Unit Rates of Reimbursement for Adult Day Care Service and Transportation
240.1950 Adult Day Care Fixed Unit Reimbursement Rates

SUBPART T: FINANCIAL REPORTING

Section
240.2020 Financial Reporting of Chore-Housekeeping and Homemaker Services
240.2030 Unallowable Costs for Chore-Housekeeping and Homemaker Services
240.2040 Minimum Direct Service Worker Costs for Chore-Housekeeping and Homemaker Services
240.2050 Cost Categories for Chore-Housekeeping and Homemaker Services

AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(1) of the Illinois Act on the Aging (Ill. Rev. Stat. 1989, ch. 23, pars. 6104.02 and 6104.01(1)).

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendments at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendments at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendments at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency

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amendments at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendments at 15 Ill. Reg. 2838 effective, February 1, 1991 for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendments at 15 Ill. Reg. 14335, effective October 1, 1991, for a maximum of 150 days; emergency amendments at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendments suspended at 16 Ill. Reg. 1744; emergency amendments at 16 Ill. Reg. 2930 effective February 5, 1992, for a maximum of 150 days; emergency amendments modified and reinstated at 16 Ill. Reg. 2930 ; emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, for a maximum of 146 days.

NOTE: Bold faced type denotes statutory language.

SUBPART G: NON-FINANCIAL REQUIREMENTS

Section 240.720 Clients Prior July 1, 1990
EMERGENCY

Effective with the delivery of service(s) beginning March 1, 1992, ~~I~~individuals whose eligibility for the Community Care Program (CCP) was determined prior to July 1, 1990, and who have been continuously served since determination of initial eligibility shall be required to meet the minimum scores on the Determination of Need as outlined in Section 240.725.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, for a maximum of 146 days)

Section 240.725 Maximum Payment Levels for Service~~Clients After November 15, 1991~~

EMERGENCY

Individuals ~~whose eligibility for the Community Care Program (CCP) is~~ determined eligible to receive Community Care Program (CCP) services ~~on or after the effective date of this Section~~ shall have their need for long term care established by receipt of a minimum score of twenty-nine ~~(29)~~ points on the Determination of Need, fifteen ~~(15)~~ of which must be scored on Total Impairment, which includes Part A and the Mini-Mental State Examination (refer to Section 240.715). The following maximum monthly service dollars

are calculated according to the applicant's/client's total Determination of Need score. These maximum monthly service dollars will be adjusted by the Department to be consistent with any future unit rate adjustments for Community Care Program (CCP) vendors.

a) Individuals scoring from 29 thru 32 points shall be eligible for services costing no less than $1 and not to exceed $190 monthly.

b) Individuals scoring from 33 thru 36 points shall be eligible for services costing no less than $1 and not to exceed $300 monthly.

c) Individuals scoring from 37 thru 45 points shall be eligible for services costing no less than $1 and not to exceed $480 monthly.

d) Individuals scoring from 46 thru 56 points shall be eligible for services costing no less than $1 and not to exceed $600 monthly.

e) Individuals scoring from 57 thru 67 points shall be eligible for services costing no less than $1 and not to exceed $700 monthly.

f) Individuals scoring from 68 thru 78 points shall be eligible for services costing no less than $1 and not to exceed $910 monthly.

g) Individuals scoring from 79 thru 87 points shall be eligible for services costing no less than $1 and not to exceed $1240 monthly.

h) Individuals scoring from 88 thru 100 points shall be eligible for services costing no less than $1 and not to exceed $1445 monthly.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, for a maximum of 146 days)

SUBPART H: FINANCIAL REQUIREMENTS

Section 240.800 Financial Factors
EMERGENCY

a) ~~The requirements of Sections 240.810 through 240.875 are not applicable to those individuals determined eligible prior to July 1, 1983, and who have had continuous service since that time. However, a~~All clients of the Community Care Program are required to provide information relative to the value and types of assets owned.

b) ~~The requirements of Sections 240.825 through 240.875 are not applicable to those individuals determined eligible prior to July 6, 1982, and who have had continuous service since that time. However, a~~All clients of the Community Care Program are required to provide information relative to the amount and source of all income.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992 for a maximum of 146 days)

Section 240.810 Assets
EMERGENCY

a) To be eligible to receive Community Care Program (CCP) services, an applicant/client shall not own non-exempt assets having a combined value in excess of $10,000. ~~(Refer to Section 240.800.)~~

b) The value of non-exempt assets shall be considered in determining eligibility for the Community Care Program.

c) All assets not specifically exempt are non-exempt.

d) When a client's non-exempt assets are greater than the allowable disregard (i.e., $10,000 non-exempt assets), consideration of non-liquid assets may be deferred as follows:

1) real property may be deferred from consideration for six ~~(6)~~ months;

2) the client shall sign an agreement to dispose of the real property in excess of the allowable disregard within six ~~(6)~~ months from the date of the agreement; and

3) the six ~~(6)~~ month period for disposition may be extended an additional six ~~(6)~~ months if the client fails to dispose of the asset (through no fault of

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his/her own) despite reasonable and diligent effort.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, for a maximum of 146 days)

Section 240.825 Income
EMERGENCY

a) Documentation of all currently available income which is not specified as exempt shall be provided during the applicant's/client's determination of eligibility for the Community Care Program. ~~(Refer to Section 240.800.)~~

b) The first $25.00 of a client's earned or unearned income (other than Supplemental Security Income (SSI) or contributions from a spouse or other individual) is exempt from consideration in determining eligibility. A client is eligible for only one $25.00 exemption regardless of the types or sources or earned or unearned income.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, for a maximum of 146 days)

Section 240.855 Applicant/Client Expense for Care
EMERGENCY

Effective March 1, 1992, at the time of the next redetermination of eligibility, or no later than May 1, 1992, whichever date occurs first, ~~T~~the requirements of Section 240.855 are ~~not~~ applicable to all CCP clients, including those individuals determined eligible prior to July 6, 1982, and who have had continuous service since that time. Continuous service is defined as service which has not been terminated for any of the reasons specified in Section 240.950.

a) An eligible applicant/client of the Community Care Program (CCP) or the applicant's/client's authorized representative shall sign the Client Agreement - Plan of Care agreeing to pay a portion of all income in excess of the federal poverty level to the vendor for expense to be incurred monthly for care.

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1) Adjustments in the federal poverty level shall be made annually and shall become effective the first day of each State fiscal year.

2) Client payments to the vendor shall not exceed the client's monthly incurred expense for care.

b) Refusal by the eligible applicant/authorized representative to sign the required Client Agreement - Plan of Care for payment of the expense to be incurred monthly for care shall result in denial of the application.

c) Refusal by the client/authorized representative to sign the required Client Agreement - Plan of Care for payment of the expense to be incurred monthly for care shall result in termination of CCP services.

(Source: Emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992 for a maximum of 146 days)

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1) Heading of the Part: Residential Mortgage License Act of 1987

2) Code Citation: 38 Ill. Adm. Code 450

3) Section Numbers / Emergency Action

Section Numbers	Emergency Action
450.440	Amendment
450.1010	Amendment
450.1250	Amendment
450.1335	Amendment
450.1340	Amendment

4) Statutory Authority:

Implementing and authorized by the Residential Mortgage License Act of 1987 (Ill. Rev. Stat. 1989, ch. 17, par. 2324-1(g)).

5) Effective Date of Emergency Amendments: February 10, 1992.

6) If this Emergency Amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: These emergency amendments will remain in effect for the 150-day period.

7) Date filed in Agency's principal office: February 10, 1992

8) Reason for Emergency:

The Agency has found that major secondary market investors (for instance, the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC)), allow deposit of escrow funds in other institutions as delineated in the emergency amendment to Section 450.440 of this Part. It has come to the attention of the Agency that the present wording of this Section created a restriction which hindered prudent business practices while providing no demonstrable benefit to borrowers.

With little warning, mortgage interest rates have been undergoing a period of wide fluctuation, including reduction and increase. Historically, declining interest rates have resulted in an extraordinary volume of mortgage loan applications. This volume is artificially inflated by the practice of multiple applications, resulting in multiple appraisal, credit reporting and title company orders for the

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same property. The duplication creates a demand for processing services which the market realistically cannot meet. Consequently, many homeowners or prospective home purchasers are frustrated in their attempts to obtain timely financing. Accordingly, the Agency is filing an emergency amendment to Section 450.1335. In essence, the amendment discourages multiple mortgage applications; because the mortgage loan applicant will have a vested financial interest in his/her application, through the payment of a competitively priced upfront fee to lock in an interest rate. Simultaneously, to avoid problems which arose in 1986 and 1987 from similar situations, the Agency has mandated explicit standards under which such fee may be collected.

9) A Complete Description of the Subjects and Issues Involved:

The rules in this Part implement the Residential Mortgage License Act of 1987 (Ill. Rev. Stat. 1989, ch. 17, pars. 2321-1 et seq.) which creates a thorough regulatory structure and consumer protection provision that recognizes the growing complexity and volume of mortgage banking in Illinois.

These amendments represent the culmination of a comprehensive review by the Agency. The proposed changes include the following Sections.

450.440 Escrow: The amendment to this section is twofold: a technical amendment for consistency with the amendment to Section 450.1335, plus a broader definition of the institutions into which escrow funds may be deposited.

450.1010 Loan Brokerage Agreement: Technical amendment for consistency with the amendment to Section 450.1335.

450.1250 Good Faith Requirements: Technical amendment for consistency with the amendment to Section 450.1335.

450.1335 Fees and Charges Prior to Closing: The amendment replaces the "True-Rate Lock In" provision with a "Rate-Lock Fee" which can be collected by a Licensee, provided a written Rate-Lock Fee Agreement states certain specific information with respect to the terms of the mortgage. Further, the amendment requires that such fee shall be deposited in escrow.

450.1340 Refunds on Failure to Close: Technical amendment for consistency with the amendment to Section 450.1335.

10) Are there any proposed amendments to this Part pending? No

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11) Statement of Statewide Policy Objectives: This rulemaking has no effect on local governmental units.

12) Information and questions regarding these amendments shall be directed to:

Mr. Jay R. Stevenson, Deputy Commissioner
Illinois Commissioner of Savings and Residential Finance
(Formerly the Commissioner of Savings and Loan Associations)
500 East Monroe Street, Suite 800
Springfield, Illinois 62701-1509
Telephone: (217) 782-6169

The full text of the Emergency Amendments begins on the next page.

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NOTICE OF EMERGENCY AMENDMENTS

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER III: COMMISSIONER OF SAVINGS AND LOAN ASSOCIATIONS

PART 450
RESIDENTIAL MORTGAGE LICENSE ACT OF 1987

SUBPART A: DEFINITIONS

SUBPART B: FEES

SUBPART C: LICENSING

SUBPART D: OPERATIONS AND SUPERVISION

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SUBPART N: ADMINISTRATIVE HEARING PROCEDURES

Section

AUTHORITY: Implementing and authorized by the Residential Mortgage License Act of 1987 (Ill. Rev. Stat. 1989, ch. 17, pars. 2321-1 et seq.).

SOURCE: Filed January 18, 1974; amended at 2 Ill. Reg. 2, p. 1, effective January 16, 1978; codified at 8 Ill. Reg. 4524; amended at 9 Ill. Reg. 17393, effective October 24, 1985; Part repealed, new Part adopted by emergency action at 12 Ill. Reg. 3079, effective January 13, 1988, for a maximum of 150 days; Part repealed, New Part adopted at 12 Ill. Reg. 8685, effective May 10, 1988; emergency amendments at 12 Ill. Reg. 9721, effective May 18, 1988, for a maximum of 150 days; adopted at 12 Ill. Reg. 17093, effective October 11, 1988; amended at 13 Ill. Reg. 17056, effective October 20, 1989; amended at 15 Ill. Reg. 8580, effective

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May 28, 1991; emergency amendments at 16 Ill. Reg. 2915, effective February 10, 1992, for a maximum of 150 days.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

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SUBPART D: OPERATIONS AND SUPERVISION

Section 450.440 Escrow
EMERGENCY

a) Escrow funds shall be disclosed as a part of the licensee's financial statement package. Escrow funds collected pursuant to a Rate-Lock Fee Agreement and escrow funds for payment of real property taxes or any other purpose authorized by the mortgage contract shall be maintained in a ~~Federally insured~~ depository institution as described in subsection (b) below and may not be commingled with any licensee funds.

b) Where a Rate-Lock Fee has been collected pursuant to Section 450.1335 of this Part, or where servicing includes maintenance of an escrow (impound) account for payment of tax bills and/or hazard insurance premiums, the funds collected for such account or Rate-Lock Fee shall be placed in a Federally insured depository institution, or a Federal Home Loan Bank, or a Federal Reserve Bank, or other similar Government-sponsored enterprise, or a financial institution chartered under the Illinois Savings Associations Banking Act, to be removed and used only for:

1) authorized payments from the related escrow (impound) account for tax bills and/or hazard insurance premiums;

2) refunds to the mortgagor;

3) transferring to another ~~Federally insured depository~~ institution~~,~~ as described in subsection (b) above;

4) forwarding to the appropriate servicer in case of a transfer of servicing;

5) any other purpose authorized by the mortgage contract; ~~or,~~

6) compliance with a regulatory or court order~~.~~; or

7) possession by the licensee of a Rate-Lock Fee pursuant to Section 450.1335 of this Part.

(Source: Emergency Amendment at 16 Ill. Reg. 2915, effective February 10, , 1992, for a maximum of 150 days)

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SUBPART I: LOAN BROKERAGE PRACTICES

Section 450.1010 Loan Brokerage Agreement
EMERGENCY

Before a mortgage loan applicant, also referred to herein as "borrower" or "customer", signs a completed residential mortgage loan application or gives the licensee any consideration, whichever comes first, a loan brokerage agreement shall be required and shall be in writing and signed by both the mortgage loan applicant and a licensee whose services to such customer shall be loan brokering as defined at Section 1-4(o) of the Act.

a) The loan brokerage agreement shall carry a clear and conspicuous statement that, upon request, a copy shall be made available to the borrower or the borrower's attorney for review prior to signing.

b) Both the licensee's authorized representative and the borrower shall sign and date the loan brokerage agreement at the same time, and a copy of the executed agreement shall be given to the customer at the time of signing.

c) The loan brokerage agreement shall contain an explicit description of the services the licensee agrees to perform for the borrower and a good faith estimate of all consideration and remuneration to be exchanged in conjunction with such services. In the same area of the agreement shall be language, of prominence equal to or greater than such estimate, listing the types of situations or conditions which could materially affect the amounts indicated due to details which could not be known by the licensee at the time of signing the loan brokerage agreement. Examples of such situation or conditions may include, but not be limited to, an appraised value different from that estimated by the borrower or credit obligations which the borrower fails to report.

d) The loan brokerage agreement shall carry a clear and conspicuous statement as to the conditions under which the borrower is obligated to pay the licensee.

e) The loan brokerage agreement shall provide that if the licensee makes false or misleading statements in such agreement, the borrower may, upon written notice:

1) Void the agreement;

2) Recover monies paid to the broker for which no services have been performed; and

3) Recover actual costs, including attorney fees for enforcing the borrower's rights under the loan brokerage agreement.

f) The loan brokerage agreement shall incorporate by reference the "Loan Brokerage Disclosure Statement" described in Section 450.1020 of this Subpart.

g) Except for a Rate-Lock Fee Agreement in accordance with Section 450.1335(b), the ~~The~~ loan brokerage agreement shall be the only agreement between the borrower and licensee with respect to a single loan; except, the licensee shall also provide to the customer any disclosure statement necessary to comply with Federal and State requirements, including but not limited to, the Consumer Protection Credit Act (15 U.S.C. 1601), Equal Credit Opportunity Act (Title VII), and Truth in Lending Act (Title I) and Consumer Fraud and Deceptive Business Practices Act (Ill. Rev. Stat. 1989, ch. 121½, par. 261 et seq.).

(Source: Emergency Amendment at 16 Ill. Reg. 2915, effective February 10, , 1992, for a maximum of 150 days)

SUBPART K: GENERAL LENDING PRACTICES

Section 450.1250 Good Faith Requirements
EMERGENCY

a) For the purpose of this Part, "good faith" means honesty in fact in the conduct of the transaction.

b) Any disclosure or action required by the Act or this Part shall be made in good faith.

c) A licensee shall not accept ~~an application~~ a fee or charge for a residential mortgage loan application, unless: ~~1) The~~ the licensee ~~has a good faith belief~~ is able to demonstrate to the Commissioner that if its normal residential mortgage loan requirements are met, there is a reasonable likelihood that a loan commitment will be issued for such loan for the amount, term, rate, charges and other conditions set forth in the loan application and the applicable disclosures and document required by this Part~~;~~.

~~2) The licensee, at the time of receipt of the application, advises the applicant in writing of the requirements of this Section with which the licensee does not expect to be able to comply.~~

~~If the completed application is not personally delivered to the licensee by the mortgage loan applicant, the licensee shall send such notice to the applicant within three (3) business days after receipt of the application.~~

d) A licensee who has accepted an application for a loan to purchase residential real estate shall make a good faith effort to process the application within the time specified in the residential mortgage loan application.

(Source: Emergency Amendment at 16 Ill. Reg. 2915, effective February 10, , 1992, for a maximum of 150 days)

SUBPART L: COMMITMENT AND CLOSING PRACTICES

Section 450.1335 Fees and Charges Prior to Closing
EMERGENCY

a) ~~No~~ A licensee ~~may~~ shall not require a borrower to pay any fees or charges prior to the loan closing, except:

1) Charges to be incurred by the licensee on behalf of the borrower for services from third parties necessary to process the application, such as for credit reports and appraisals; and ~~Those in the nature of application fees and charges to be incurred by the licensee on behalf of the borrower to be paid to parties such as credit agencies and appraisers; and~~

2) A Rate-Lock Fee, provided: ~~Those fees that are demonstrably commensurate with value provided by a licensee. A commitment fee may be charged prior to closing only if a licensee is able to demonstrate that:~~

A) ~~The commitment provided was written~~ A Rate-Lock Fee Agreement is in writing and ~~accepted~~ signed by both the licensee and prospective borrower;

B) ~~There was reasonable likelihood that a loan~~

~~could be closed pursuant to the terms of the commitment;~~ The Rate-Lock Fee Agreement shall state all of the following:

1) The expiration date of the Rate-Lock Fee Agreement,

2) The amount of the loan,

3) The maximum interest rate of the loan,

4) The term of the loan, and

5) The maximum discount (points) to be paid;

~~c)~~ ~~The value provided to the prospective borrower by the commitment was sufficient to justify the amount of the fee; and~~

~~B~~C) The licensee is able to demonstrate to the Commissioner that

1) The licensee ~~was~~ is able to perform under the terms of the ~~commitment.~~ Rate-Lock Fee Agreement; and

2) Subject to verification, the information submitted by the borrower indicates that the loan will be approved in accordance with the Rate-Lock Fee Agreement;

D) Such fee does not exceed one per cent (1%) of the loan amount; and

E) The Rate-Lock Fee is deposited in escrow with the licensee in accordance with the requirements of Section 450.440 of this Part, for the following distribution:

1) The Rate-Lock Fee is credited to the borrower at closing; or

2) The Rate-Lock Fee must be refunded if the loan does not close in accordance with the Rate-Lock Fee Agreement, except that the Rate-Lock Fee may be retained by the licensee upon the licensee's ability to demonstrate to the Commissioner any of the

following reasons:

i) The borrower withdraws the loan application;

ii) The borrower has made a material misrepresentation on the loan application; or

iii) The borrower has failed to provide documentation necessary to the processing or closing of the loan;

3) When the Rate-Lock Fee is to be retained, the licensee shall, ten (10) days prior to taking possession of the fee, send a written notice to the borrower stating the reason for retaining the fee.

b) For each violation of this section, the Commissioner may fine a licensee up to Five Hundred Dollars ($500) in addition to all other actions authorized under the Act and Rules. ~~Notwithstanding the foregoing, a licensee may require commitment fees or points in exchange for delivery of a True-Rate-Lock-In. Such fees or points must be refunded if the residential mortgage loan does not close except when failure to close was due to action or failure to act by the borrower.~~

~~c) For purposes of this Section, "True-Rate-Lock-In" means issuing an unconditional written loan commitment at stated terms and interest rate without any qualification. A lender's commitment which contains a statement to the effect that the interest rate will be "x percent, or the rate in effect at loan closing, whichever is higher", or similar provision, does not constitute an unconditional written commitment. However, the following are not considered conditional:~~

~~1) A statement that the commitment is for a limited time (but the loan must be closed within the specified period of time).~~

~~2) A statement that the commitment is based upon information provided by the borrower and verifications of such information received by the licensee in the course of processing the application, or upon the execution and receipt of~~

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~~standard mortgage documentation which shall include the documents required for that individual loan product being offered by the licensee.~~

~~3)~~ ~~A statement that it is understood there will be no change in the borrower's financial circumstances prior to closing which would result in the borrower's ineligibility for the loan based on the standards applied by the licensee in issuing the commitment. For example, such a statement might address the continued employment and creditworthiness of the applicant or total amount of outstanding indebtedness.~~

~~4)~~ ~~A statement that the commitment is based upon normal requirements that the credit of the obliger and the security for the loan are at the time of closing the same as represented in the application for the loan. For example, this type of statement could deal with the condition of title to the mortgaged premises, or the construction or rehabilitation of the building.~~

(Source: Emergency Amendment at 16 Ill. Reg. 2915, effective February 10, , 1992, for a maximum of 150 days)

Section 450.1340 Refunds on Failure to Close
EMERGENCY

If a residential mortgage loan is not closed, all the licensee's ~~application fees and~~ charges as described in Section 450.1335(a)(1) shall be refunded to the borrower, except:

a) To the extent a written agreement between the borrower and licensee or a written notification required by this Part specifies that they are nonrefundable; and

b) To the extent such ~~application fees and~~ charges were incurred by the licensee on behalf of the borrower ~~and were paid to~~ for services from third parties necessary to process the application, such as credit reports ~~agencies~~ and appraisals. ~~appraisers; or~~

~~c)~~ ~~When failure to close was due to action or failure to act by the borrowers.~~

(Source: Emergency Amendment at 16 Ill. Reg. 2915, effective February 10, , 1992, for a maximum of 150 days)

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NOTICE OF MODIFICATION TO MEET THE PROHIBITION
BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

1) Heading of the Part: Community Care Program

2) Code Citation: 89 Ill. Adm. Code 240

3) Section Numbers: Action:

240.430	Amendment Modification
240.435	Amendment Reinstatement
240.720	Amendment Reinstatement
240.725	Amendment Reinstatement

4) Date Notice of Proposed Amendments Published in the Register:

December 2, 1991 (issue date) 15 Ill. Reg. 17007

5) Date JCAR Statement of Prohibition Published in the Register:

January 24, 1992 (issue date) 16 Ill. Reg. 1744

6) Summary of Action Taken by the Agency:

Pursuant to the Joint Committee on Administrative Rules request to modify Section 240.430 with respect to the proposed rules entitled Community Care Program (89 Ill. Adm. Code 240) the Department has added the following as subsection 240.430c):

> Effective April 1, 1992, Case Coordination Units are to provide a copy of any notice of adverse action to an applicant's/client's authorized representative, if the client has earned ten points on the Mini-Mental State Examination (MMSE). If the authorized representative is a family member residing with the client, the single notice to the client will suffice.

In addition to and contingent upon filing this modification with the Illinois Administrative Code Division, the Joint Committee in its February 4, 1992, meeting voted to Withdraw the Prohibition and to certify No Objection on the above proposed rule filing thereby reinstating the rule filing effective February 5, 1992.

The full text of the Sections of the proposed amendments being modified and reinstated is identical to the text of the modified

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emergency amendments which appears in this issue of the Register on page 2904.

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BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 240
COMMUNITY CARE PROGRAM

SUBPART A: GENERAL PROGRAM PROVISIONS

SUBPART B: SERVICE DEFINITIONS

SUBPART C: RIGHTS AND RESPONSIBILITIES

SUBPART D: APPEALS

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BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

SUBPART E: APPLICATION

SUBPART F: ELIGIBILITY

SUBPART G: NON-FINANCIAL REQUIREMENTS

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BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

SUBPART H: FINANCIAL REQUIREMENTS

SUBPART I: DISPOSITION OF DETERMINATION

SUBPART J: SPECIAL SERVICES

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SUBPART K: TRANSFERS

SUBPART L: ADMINISTRATIVE SERVICE CONTRACT

SUBPART M: CASE COORDINATION UNITS AND VENDORS

SUBPART N: CASE COORDINATION UNITS

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SUBPART O: VENDORS

SUBPART P: VENDOR PROCUREMENT

SUBPART R: ADVISORY COMMITTEES

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BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

240.1850 Technical Rate Review Advisory Committee

SUBPART S: VENDOR RATES

Section
240.1910 Establishment of Fixed Unit Rates
240.1920 Contract Specific Variations
240.1930 Fixed Unit Rates of Reimbursement for Chore-Housekeeping and Homemaker Services
240.1940 Fixed Unit Rates of Reimbursement for Adult Day Care Service and Transportation
240.1950 Adult Day Care Fixed Unit Reimbursement Rates

SUBPART T: FINANCIAL REPORTING

Section
240.2020 Financial Reporting of Chore-Housekeeping and Homemaker Services
240.2030 Unallowable Costs for Chore-Housekeeping and Homemaker Services
240.2040 Minimum Direct Service Worker Costs for Chore-Housekeeping and Homemaker Services
240.2050 Cost Categories for Chore-Housekeeping and Homemaker Services

AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(1) of the Illinois Act on the Aging (Ill. Rev. Stat. 1989, ch. 23, pars. 6104.02 and 6104.01(1)).

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendments at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendments at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendments at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendments at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January

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NOTICE OF MODIFICATION TO MEET THE PROHIBITION
BY THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendments at 15 Ill. Reg. 2838 effective, February 1, 1991 for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendments at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of 150 days; emergency amendments at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendments suspended at 16 Ill. Reg. 1744; emergency amendments at 16 Ill. Reg. 2930 effective February 5, 1992, for a maximum of 150 days; emergency amendments modified and reinstated at 16 Ill. Reg. 2930; amended at 16 Ill. Reg. ____, effective _____.

NOTE: Bold faced type denotes statutory language.

Section 240.430 Informal Review Findings
EMERGENCY

a) Within sixty calendar days from the date of receipt of the Notice of Appeal to Department on Aging form, the Department shall conduct an informal review and issue an Appeal Findings Notice which may be delayed pending an extension of time caused by the appellant.

b) The Appeal Findings Notice shall clearly state the facts determined and decision of the Department based upon the informal review. Copies shall be sent to all parties to the appeal.

1) If the appeal is upheld, based upon the Department decision resulting from the informal review, the appeal file shall be closed.

2) If the appeal is denied, based upon the Department decision resulting from the informal review, the appellant/authorized representative shall be advised of their right to request a formal hearing.

A) The appellant/authorized representative must advise the Department of the intent to request a formal hearing, either by telephone or in writing, to be followed by submission to the Department of a completed and signed Request for Hearing form.

B) The Department must receive the Request for Formal Hearing form on or before fifteen

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calendar days from the date the Appeal Findings Notice is issued.

C) If the Department does not receive the required form within the time frame specified above, the request for a formal hearing shall be denied and the appeal file shall be closed.

c) Effective April 1, 1992, Case Coordination Units are to provide a copy of any notice of adverse action to an applicant's/client's authorized representative, if the client has earned ten points on the Mini-Mental State Examination (MMSE). If the authorized representative is a family member residing with the client, the single notice to the client will suffice.

(Source: Emergency amendments modified and reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

Section 240.435 Withdrawing an Appeal
EMERGENCY

a) The appellant/authorized representative, may withdraw the appeal at any time prior to or during the appeal process. The withdrawal may be submitted in writing or by telephone.

b) The Department shall acknowledge the withdrawal of appeal and advise the appellant/authorized representative that the appeal is formally closed, in writing, by certified mail, return receipt requested.

c) The Department shall furnish copies of the acknowledgement of withdrawal to all interested parties to the appeal.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

Section 240.720 Clients Prior to July 1, 1990
EMERGENCY

Individuals whose eligibility for the Community Care Program (CCP) was determined prior to July 1, 1990, and who have been continuously served since determination of initial eligibility

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shall have their need for long term care established by receipt of the following scores on the Determination of Need:

a) Individuals having a combined score on Total Impairment Part A, (which includes the MMSE and Part A) and Part B from zero through twenty-eight points, or who have twenty-nine or more points overall but fail to receive at least fifteen points on Total Impairment shall be eligible for services costing no less than $1 and not to exceed $100 monthly;

b) Individuals having a combined score on Part A and Part B of twenty-nine points or more with a minimum of fifteen points on Part A shall have their need for long term care established in accordance with Section 240.725.

c) The above monthly maximums allowed, which are based upon the Determination of Need score, will be adjusted by the Department as needed to accommodate unit rate adjustments for the providers.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

Section 240.725 Clients After November 15, 1991
EMERGENCY

Individuals whose eligibility for the Community Care Program (CCP) is determined on or after the effective date of this Section shall have their need for long term care established by receipt of a minimum score to twenty-nine points on the Determination of Need, fifteen of which must be scored on Total Impairment, which includes Part A and the Mini-Mental State Examination (refer to Section 240.715). The following maximum monthly service dollars are calculated according to the applicant's/client's total Determination of Need score. These maximum monthly service dollars will be adjusted by the Department to be consistent with any future unit rate adjustments for Community Care Program vendors.

a) Individuals scoring from 29 thru 32 points shall be eligible for services costing no less than $1 and not to exceed $190 monthly.

b) Individuals scoring from 33 thru 36 points shall be eligible for services costing no less than $1 and not to exceed $300 monthly.

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c) Individuals scoring from 37 thru 45 points shall be eligible for services costing no less than $1 and not to exceed $480 monthly.

d) Individuals scoring from 46 thru 56 points shall be eligible for services costing no less than $1 and not to exceed $600 monthly.

e) Individuals scoring from 57 thru 67 points shall be eligible for services costing no less than $1 and not to exceed $700 monthly.

f) Individuals scoring from 68 thru 78 points shall be eligible for services costing no less than $1 and not to exceed $910 monthly.

g) Individuals scoring from 79 thru 87 points shall be eligible for services costing no less than $1 and not to exceed $1240 monthly.

h) Individuals scoring from 88 thru 100 points shall be eligible for services costing no less than $1 and not to exceed $1445 monthly.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

ILLINOIS COMMERCE COMMISSION

NOTICE OF WITHDRAWAL OF PROPOSED RULES

1) Heading of the Part: Commodity Group Definitions

2) Code Citation: 92 Ill. Adm. Code 1311

3) Section Numbers: 1311.10 — Proposed Action: New Part

4) Date Notice of Proposed Rules Published in the Illinois Register:
March 22, 1991 at 15 Ill. Reg. 4195

5) Reason for Withdrawal:
This proposal is being withdrawn because the Agency is unable to effect adoption within the prescribed one year period. Revisions will be made to the text and the rule will be reproposed in the near future.

DEPARTMENT ON AGING

NOTICE OF MODIFICATION TO EMERGENCY AMENDMENTS
IN RESPONSE TO THE SUSPENSION BY THE JOINT COMMITTEE ON
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1) Heading of the Part: Community Care Program

2) Code Citation: 89 Ill. Adm. Code 240

3) Section Numbers:

240.430
240.435
240.720
240.725

4) Notice of Emergency Amendments Published in the Illinois Register:

December 2, 1991 (issue date) 15 Ill. Reg. 17398

5) JCAR Statement of Suspension to Emergency Amendments published in the Illinois Register:

January 24, 1992 (issue date) 16 Ill. Reg. 1744

6) Date agency submitted this modification to JCAR for approval:

February 4, 1992

7) Summary of Action Taken by the Agency:

Pursuant to the Joint Committee on Administrative Rules request to modify Section 240.430 with respect to the emergency rules entitled Community Care Program (89 Ill. Adm. Code 240) the Department has added the following as subsection 240.430c):

> Effective April 1, 1992, Case Coordination Units are to provide a copy of any notice of adverse action to an applicant's/client's authorized representative, if the client has earned ten points on the Mini-Mental State Examination (MMSE). If the authorized representative is a family member residing with the client, the single notice to the client will suffice.

In addition to and contingent upon filing this modification with the Illinois Administrative Code Division, the Joint

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Committee in its February 4, 1992, meeting voted to Withdraw the Suspension and to certify No Objection on the above emergency rule filing thereby reinstating the rule filing effective February 5, 1992.

The full text of the Sections of the emergency amendments being modified and reinstated begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 240
COMMUNITY CARE PROGRAM

SUBPART A: GENERAL PROGRAM PROVISIONS

SUBPART B: SERVICE DEFINITIONS

SUBPART C: RIGHTS AND RESPONSIBILITIES

SUBPART D: APPEALS

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SUBPART E: APPLICATION

SUBPART F: ELIGIBILITY

SUBPART G: NON-FINANCIAL REQUIREMENTS

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SUBPART H: FINANCIAL REQUIREMENTS

SUBPART I: DISPOSITION OF DETERMINATION

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SUBPART J: SPECIAL SERVICES

SUBPART K: TRANSFERS

SUBPART L: ADMINISTRATIVE SERVICE CONTRACT

SUBPART M: CASE COORDINATION UNITS AND VENDORS

SUBPART N: CASE COORDINATION UNITS

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SUBPART O: VENDORS

SUBPART P: VENDOR PROCUREMENT

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SUBPART R: ADVISORY COMMITTEES

SUBPART S: VENDOR RATES

SUBPART T: FINANCIAL REPORTING

AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(1) of the Illinois Act on the Aging (Ill. Rev. Stat. 1989, ch. 23, pars. 6104.02 and 6104.01(1)).

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendments at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendments at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendments at 9 Ill. Reg. 14011, effective

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August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendments at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendments at 15 Ill. Reg. 2838 effective, February 1, 1991 for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendments at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of 150 days; emergency amendments at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendments suspended at 16 Ill. Reg. 1744; emergency amendments at 16 Ill. Reg. 2930 effective February 5, 1992, for a maximum of 150 days; emergency amendments modified and reinstated at 16 Ill. Reg. 2930.

NOTE: Bold faced type denotes statutory language.

Section 240.430 Informal Review Findings
EMERGENCY

a) Within sixty calendar days from the date of receipt of the Notice of Appeal to Department on Aging form, the Department shall conduct an informal review and issue an Appeal Findings Notice which may be delayed pending an extension of time caused by the appellant.

b) The Appeal Findings Notice shall clearly state the facts determined and decision of the Department based upon the informal review. Copies shall be sent to all parties to the appeal.

1) If the appeal is upheld, based upon the Department decision resulting from the informal review, the appeal file shall be closed.

2) If the appeal is denied, based upon the Department decision resulting from the informal review, the appellant/authorized representative shall be advised of their right to request a formal hearing.

A) The appellant/authorized representative must advise the Department of the intent to request a formal hearing, either by telephone or in writing, to be followed by submission to the Department of a completed and signed Request for Hearing form.

B) The Department must receive the Request for Formal Hearing form on or before fifteen calendar days from the date the Appeal Findings Notice is issued.

C) If the Department does not receive the required form within the time frame specified above, the request for a formal hearing shall be denied and the appeal file shall be closed.

c) Effective April 1, 1992, Case Coordination Units are to provide a copy of any notice of adverse action to an applicant's/client's authorized representative, if the client has earned ten points on the Mini-Mental State Examination (MMSE). If the authorized representative is a family member residing with the client, the single notice to the client will suffice.

(Source: Emergency amendments modified and reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

Section 240.435 Withdrawing an Appeal
EMERGENCY

a) The appellant/authorized representative, may withdraw the appeal at any time prior to or during the appeal process. The withdrawal may be submitted in writing or by telephone.

b) The Department shall acknowledge the withdrawal of appeal and advise the appellant/authorized representative that the appeal is formally closed, in writing, by certified mail, return receipt requested.

c) The Department shall furnish copies of the acknowledgement of withdrawal to all interested parties to the appeal.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

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Section 240.720 Clients Prior to July 1, 1990
EMERGENCY

Individuals whose eligibility for the Community Care Program (CCP) was determined prior to July 1, 1990, and who have been continuously served since determination of initial eligibility shall have their need for long term care established by receipt of the following scores on the Determination of Need:

a) Individuals having a combined score on Total Impairment Part A, (which includes the MMSE and Part A) and Part B from zero through twenty-eight points, or who have twenty-nine or more points overall but fail to receive at least fifteen points on Total Impairment shall be eligible for services costing no less than $1 and not to exceed $100 monthly;

b) Individuals having a combined score on Part A and Part B of twenty-nine points or more with a minimum of fifteen points on Part A shall have their need for long term care established in accordance with Section 240.725.

c) The above monthly maximums allowed, which are based upon the Determination of Need score, will be adjusted by the Department as needed to accommodate unit rate adjustments for the providers.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

Section 240.725 Clients After November 15, 1991
EMERGENCY

Individuals whose eligibility for the Community Care Program (CCP) is determined on or after the effective date of this Section shall have their need for long term care established by receipt of a minimum score to twenty-nine points on the Determination of Need, fifteen of which must be scored on Total Impairment, which includes Part A and the Mini-Mental State Examination (refer to Section 240.715). The following maximum monthly service dollars are calculated according to the applicant's/client's total Determination of Need score. These maximum monthly service dollars will be adjusted by the Department to be consistent with any future unit rate adjustments for Community Care Program vendors.

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a) Individuals scoring from 29 thru 32 points shall be eligible for services costing no less than $1 and not to exceed $190 monthly.

b) Individuals scoring from 33 thru 36 points shall be eligible for services costing no less than $1 and not to exceed $300 monthly.

c) Individuals scoring from 37 thru 45 points shall be eligible for services costing no less than $1 and not to exceed $480 monthly.

d) Individuals scoring from 46 thru 56 points shall be eligible for services costing no less than $1 and not to exceed $600 monthly.

e) Individuals scoring from 57 thru 67 points shall be eligible for services costing no less than $1 and not to exceed $700 monthly.

f) Individuals scoring from 68 thru 78 points shall be eligible for services costing no less than $1 and not to exceed $910 monthly.

g) Individuals scoring from 79 thru 87 points shall be eligible for services costing no less than $1 and not to exceed $1240 monthly.

h) Individuals scoring from 88 thru 100 points shall be eligible for services costing no less than $1 and not to exceed $1445 monthly.

(Source: Emergency amendments reinstated at 16 Ill. Reg. 2930, effective February 5, 1992)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

WITHDRAWAL OF FILING SUSPENSION OF EMERGENCY RULEMAKING

DEPARTMENT ON AGING

Heading of Part: Community Care Program

Code Citation: 89 Ill. Adm. Code 240

Date Originally Published in Illinois Register: 12/2/91
15 Ill. Reg. 17398

Date Filing Prohibition Published in Illinois Register: 1/24/92
15 Ill. Reg. 17398

Date Filing Prohibition Became Effective: 1/8/92

Date Filing Prohibition Withdrawn: 2/4/92

The Joint Committee on Administrative Rules hereby Certifies that, pursuant to Section 7.06a of the Illinois Administrative Procedure Act, and contingent upon the agreements for modifications indicated on the Certificate of Withdrawal of the suspension, the Joint Committee, at its meeting on 2/4/92, has withdrawn the suspension against the filing of the Department on Aging's emergency rule entitled Community Care Program (89 Ill. Adm. Code 240). The Committee originally issued this suspension at its 1/8/92 meeting.

Please take notice that the emergency rule is no longer suspended and the agency is no longer prohibited from enforcing or invoking the rulemaking as modified in accordance with agreements between the agency and the Joint Committee on Administrative Rules.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

WITHDRAWAL OF FILING PROHIBITION OF PROPOSED RULEMAKING

DEPARTMENT OF INSURANCE

Heading of Part: Minimum Standards for Individual and Group Medicare Supplement Insurance

Code Citation: 50 Ill. Adm. Code 2008

Date Originally Published in Illinois Register: 10/18/91
15 Ill. Reg. 14859

Date Filing Prohibition Published in Illinois Register: 1/24/92
16 Ill. Reg. 1743

Date Filing Prohibition Became Effective: 1/8/92

Date Filing Prohibition Withdrawn: 2/4/92

The Joint Committee on Administrative Rules hereby Certifies that, pursuant to Section 7.06a of the Illinois Administrative Procedure Act and based on the agreed modifications to the rulemaking as indicated in the Certification of No Objection, the Joint Committee, at its meeting on 2/4/92, has withdrawn the prohibition against the filing of Section 2008 of the Department of Insurance's proposed rule entitled "Minimum Standards for Individual and Group Medicare Supplement Insurance" (50 Ill. Adm. Code 2008). The Committee originally issued this prohibition at its 1/8/92 meeting.

Please take notice that the agency is no longer prohibited from filing the rulemaking, as modified in accordance with agreements between the agency and the Joint Committee on Administrative Rules, with the Secretary of State and from enforcing or invoking the rulemaking.

SECRETARY OF STATE

NOTICE OF CORRECTION TO ADOPTED NOTICE ONLY

1) Heading of the Part: Issuance of Licenses

2) Code Citation: 92 Ill. Adm. Code 1030

3) The Notice of Adopted Amendment being corrected appeared at 16 Ill. Reg. 2182, dated February 7, 1992.

4) The information being corrected is as follows:

15) Summary and Purpose of Rule: This adopted rulemaking sets forth the procedure to be followed for an applicant prior to taking a road test at a Driver Services Facility. The proposed procedure requires the applicant to execute an affirmation under penalty of perjury that the vehicle to be used for the road test complies with the Illinois Mandatory Insurance provisions or is otherwise exempt, prior to administration of the road test.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of February 5, 1992 through February 11, 1992, and have been scheduled for review by the Committee at its March 3, 1992 meeting. Other items not contained in this published list may also be considered by the Committee at its March meeting. Members of the public wishing to express their views with respect to a rule should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules; 509 South Sixth Street, Suite 500, Springfield, IL 62701.

Second Notice Expires	Agency and Rule	Start of First Notice	JCAR Meeting
3/23/92	Department of Central Management Services, Personal Use of State Telephones (44 Ill. Adm. Code 5030)	12/20/91 15 Ill. Reg. 18013	3/3/92
3/23/92	Department of Conservation, Competitive Tournament Fishing on State Owned and/or Leased Water Areas (17 Ill. Adm. Code 115)	12/20/91 15 Ill. Reg. 18045	3/3/92
3/23/92	Department of Conservation, Regulations for the Letting of Concessions, Farm Leases, Sale of Buildings and Facilities, and Demolitions (17 Ill. Adm. Code 150)	12/20/91 15 Ill. Reg. 18055	3/3/92
3/25/92	Department of Commerce and Community Affairs, Uniform Fiscal and Administrative Standards for the Job Training Partnership Act (56 Ill. Adm. Code 2630)	8/16/91 15 Ill. Reg. 11545	3/3/92
3/25/92	Department of Rehabilitation Services, Non-Financial Eligibility Criteria (89 Ill. Adm. Code 685)	11/22/91 15 Ill. Reg. 16896	3/3/92

EXECUTIVE ORDER
92-1
EXECUTIVE ORDER CREATING THE ILLINOIS TASK FORCE ON CRIME AND CORRECTIONS

Whereas, tougher penalties and aggessive law enforcement over the past two decades have contributed to a dramatic increase in Illinois' prison population; and

Whereas, communities are safer today because of the apprehension and incarceration of dangerous offenders; and

Whereas, Illinois' prison population has more than quadrupled since 1973 and fourteen prisons were built in the last 14 years to accommodate that growth; and

Whereas, despite Illinois' aggressive prison construction initiative of recent years, its prisons are still facing potential overcrowding; and

Whereas, excessive prison crowding potentially endangers the lives of guards and other employees and invites court intervention that could force Illinois to undertake costly construction or dangerous early release programs; and

Whereas, innovative alternative methods and policies of incarceration exist that can relieve prison crowding, such as boot camps and electronic monitoring; and

Whereas, states throughout the nation are exploring ways to protect society from dangerous offenders in an affordable manner that does not require a general tax increase;

Therefore, I, Jim Edgar, order the following:

I. CREATION

There shall be established the Illinois Task Force on Crime and Corrections.

II. PURPOSE

The duties of the Task Force shall include, but not be limited to, the following:

A. to study the future needs for space in Illinois prisons, along with the potential costs, based on projections of future crime, arrest and incarceration.

B. to study alternatives to incarceration that offer cost effective means of protecting public safety and penalizing offenders.

C. to analyze current prison policies, statutes, sentencing and other factors that influence inmate populations.

D. to identify solutions that, first, protect public safety, and, second, do so in a manner that taxpayers of Illinois can afford.

III. MEMBERSHIP

A. The Task Force shall consist of 21 members as follows: one legislative member appointed by the President of the Senate, one legislative member appointed by the Minority Leader of the Senate, one legislative member appointed by the Speaker of the House, one legislative member appointed by the Minority Leader of the House, and 16 members appointed by the Governor.

B. The gubernatorial members shall be representatives of

crime victims, law enforcement, the judiciary, the bar, academia, state corrections employees and community residents.

C. The Governor shall select a chairman from among the members of the Task Force.

D. Ex officio members of the task force shall include the Director of the Illinois State Police, the Director of the Illinois Department of Corrections, the Chairman of the Prisoner Review Board, the Chief Legal Counsel to the Governor and a Special Assistant to the Governor.

E. Members will serve without compensation but may be reimbursed for expenses.

F. The Task Force will be provided staff support services by the Illinois Criminal Justice Information Authority.

G. The Task Force will release an interim report to the Governor and to the Members of the General Assembly by June 1, 1992, and a final report by December 31, 1992.

IV. EFFECTIVE DATE

This Executive Order Number 1 (1992) shall be effective upon filing with the Secretary of State and shall be repealed effective December 31, 1992.

Issued by the Governor February 6, 1992.

Filed with the Secretary of State February 6, 1992.

PROCLAMATION

92-021
EYE DONOR AWARENESS MONTH
(Revised)

Whereas, more than 40,000 adults and children in the United States benefited from corneal transplant surgery in 1991; and

Whereas, donor eyes that are not used for corneal transplant surgery are used for valuable research on blinding eye diseases; and

Whereas, donor eye tissue is being made available now more than ever before, thanks to awareness programs promoted by the Illinois Eye-Bank, the Chicago Ophthalmological Society Eye-Bank Committee and Illinois hospitals;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1992 as EYE DONOR AWARENESS MONTH in Illinois.

Issued by the Governor February 4, 1992.

Filed with the Secretary of State February 7, 1992.

92-041
ARMY ROTC WEEK

Whereas, the Army Reserve Officer's Training Corps (ROTC) provides exceptional leadership instruction at 11 of our state's leading colleges and universities; and

Whereas, the ROTC's purpose is to develop selected men and

women for positions of responsibility as officers in the active Army, Army National Guard, and Army Reserve; and

Whereas, the efficiency and vitality of our military depends to a great extent upon the high caliber of young officer accessions, more than half of whom are obtained each year through the ROTC program; and

Whereas, many civilian and government leaders in our state and nation have been ROTC members; and

Whereas, the ROTC is one of the most respected organizations in our country;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 5-11, 1992, as ARMY ROTC WEEK in Illinois, in recognition of the graduates of this outstanding program.

Issued by the Governor January 24, 1992.

Filed with the Secretary of State February 7, 1992.

92-042
ASTRONAUT REMEMBRANCE DAY

Whereas, January 28, 1992, marks the 6th anniversary of the tragic Challenger disaster; and

Whereas, through the years, 15 brave astronauts have lost their lives while pursuing the exploration of space and the betterment of mankind; and

Whereas, our recollections of the valor and bravery of these individuals will help keep their memory alive; and

Whereas, it is fitting that we honor and remember these space explorers with one minute of silence January 28. The astronauts to be honored are Virgil (Gus) Grissom, Edward White, Roger Chaffee, Ted Freeman, Charles Bassett, Elliott See, C. C. Williams, Edward Givens, Francis R. (Dick) Scobee, Michael J. Smith, Judith A. Resnik, Ronald E. McNair, Ellison S. Onizuka, Gregory B. Jarvis and Sharon Christa McAuliffe;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim January 28, 1992, as ASTRONAUT REMEMBRANCE DAY in Illinois and urge Illinoisans to take time to reflect upon the dedication of these courageous explorers.

Issued by the Governor January 24, 1992.

Filed with the Secretary of State February 7, 1992.

92-043
CARDIAC REHABILITATION WEEK

Whereas, cardiovascular diseases continue to be the number one cause of death in our nation today; and

Whereas, medical research supports the premise that cardiovascular disease mortality can be decreased by reducing cardiovascular disease risk factors through regular exercise, blood pressure control, cholesterol reduction, smoking cessation, and stress management; and

Whereas, cardiac rehabilitation provides an opportunity for cardiac patients to return to optimal physical, psychological, social, and occupational health through supervised exercise and cardiovascular disease risk factor education and modification; and

Whereas, there are more than 100 organized cardiac rehabilitation programs in the State of Illinois. The American Association of Cardiovascular and Pulmonary Rehabilitation and the Illinois Society for Cardiac Health and Rehabilitation are sponsoring Cardiac Rehabilitation Week February 10-14, 1992; and

Whereas, the event aims to increase awareness of cardiac rehabilitation and the opportunities that it provides for improved cardiovascular health and quality of life for cardiac patients;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 10-14, 1992, as CARDIAC REHABILITATION WEEK in Illinois, in recognition of the role that cardiac rehabilitation programs play in the prevention and treatment of cardiovascular diseases.

Issued by the Governor January 24, 1992.

Filed withe the Secretary of State February 7, 1992.

92-044
NUTRITION MONTH

Whereas, the Illinois Department of Public Health, along with nutrition professionals throughout Illinois and the United States, is promoting good nutrition; and

Whereas, there is a need to encourage our citizens to practice sound eating habits throughout the year in order to achieve optimum health; and

Whereas, in keeping with the theme of the national observance -- "Eat Right, America" -- all Illinoisans should become aware that proper nutrition is vital at all stages of life;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1992 as NUTRITION MONTH in Illinois and urge citizens to increase their awareness of the significance of good nutrition.

Issued by the Governor January 29, 1992.

Filed with the Secretary of State February 7, 1992.

92-045
FUTURE BUSINESS LEADERS OF
AMERICA-PHI BETA LAMBDA WEEK

Whereas, the State of Illinois recognizes the youth of our nation as the foundation of America's thriving business structure; and

Whereas, Future Business Leaders of America-Phi Beta Lambda represent nearly 200,000 young men and women who have an

enthusiastic interest in the business world. Approximately 3,500 members are Illinois citizens; and

Whereas, this national organization provides a valuable service to our communities and our young people by encouraging the development of competent, aggressive business leadership; strengthening students' self-confidence; creating a greater understanding of American enterprise; and facilitating the transition from school to work;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 9-15, 1992, as FUTURE BUSINESS LEADERS OF AMERICA-PHI BETA LAMBDA WEEK in Illinois in conjunction with the nat onal observance.

Issued by the Governor January 30, 1992.
Filed with the Secretary of State February 7, 1992.

92-046
JUNIOR HIGH STUDENT GOVERNMENT WEEK

Whereas, Illinois Association of Junior High Student Councils (IAJHSC) was established March 21, 1958, to develop leadership qualities of junior high students and educate them on the workings of a student council; and

Whereas, as members of the IAJHSC, students learn the democratic process of governing and elections. Students share ideas, meet new friends, and elect their representatives for the next year to serve on the IAJHSC Executive Board; and

Whereas, the association provides an avenue for advisors and students to exchange ideas and to solve problems by sharing experiences; and

Whereas, through their student government organization, young citizens develop leadership qualities and independence. They learn the accomplishments of teamwork, which will make them better leaders for our country tomorrow; and

Whereas, the IAJHSC will hold its 33rd state convention April 10 and 11 in Galena, with the theme "Climbing Up With Confidence";

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 10-17, 1992, as JUNIOR HIGH STUDENT GOVERNMENT WEEK in Illinois.

Issued by the Governor January 30, 1992.
Filed with the Secretary of State February 7, 1992.

92-047
FFA WEEK

Whereas, agriculture is vital to the future progress and prosperity of Illinois. Our state relies heavily on the productive efforts of those engaged in the dynamic and challenging business and technology of agriculture; and

Whereas, more than 11,200 members in the Illinois FFA

organization are studying agriculture education for careers in agriculture and agribusiness related fields, while developing leadership, cooperation, and citizenship; and

Whereas, agriculture is recognized as the backbone of our nation's heritage and provides our citizens with more than just a way of life. To emphasize this, the National FFA chose "Leadership For A Growing Planet" for its 1991-92; and

Whereas, the Illinois Association FFA's 1991-92 theme is "Excellence In Action," which highlights the innovative ideas being implemented in agriculture education and the valuable experiences such education provides;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 15-22, 1992, as FFA WEEK in Illinois and urge all citizens to recognize, encourage, and support the efforts of our young agricultural leaders.

Issued by the Governor January 31, 1992.
Filed with the Secretary of State February 7, 1992.

92-048
HARVEY J. DOMINICK DAY

Whereas, Harvey J. Dominick has given 32 years of loyal service to the State of Illinois as chief Entomologist of the Illinois Department of Public Health; and

Whereas, his many accomplishments and professional expertise are recognized throughout our state and our nation; and

Whereas, Harvey's accomplishments include serving as president of the Illinois Mosquito Control Association and regional director of the State Public Health Vector Control Conference; and

Whereas, his commitment to protecting and improving the health of our citizens have set a shining example for other public health personnel to emulate; and

Whereas, Harvey's professionalism, knowledge, and experience will be greatly missed after his much-deserved retirement;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim January 31, 1992, as HARVEY J. DOMINICK DAY, in recognition of the dedication he has shown in serving our citizens and our state.

Issued by the Governor January 31, 1992.
Filed with the Secretary of State February 7, 1992.

92-049
INTERNATIONAL WEEK

Whereas, the International Student Council at Southern Illinois University at Carbondale is celebrating its 18th anniversary of cultural, social, and educational contributions to the community; and

Whereas, SUIC has student representation from 115 countries

and ranks 11th inthe nation in foreign enrollment; and

Whereas, the International Student Council is sponsoring an "International Festival" February 10-16 that will offer cultural exhibitions and activities;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim the week of February 10-16, 1992, as INTERNATIONAL WEEK in Illinois.

Issued by the Governor January 31, 1992.
Filed with the Secretary of State February 7, 1992.

92-050
JUSTIN DART DAY

Whereas, there are 43 million Americans with disabilities and more than 1 million Illinoisans with disabling conditions; and

Whereas, people with disabilities have made great strides in the past decade regarding societal inclusion, personal equality, and independence; and

Whereas, Justin Dart, a native Illinoisan, has devoted his life to making lawmakers and leaders aware of issues important to people with disabilities; and

Whereas, Justin Dart has played a key role in forging public and private partnerships highlighting the abilities of people with disabilities; and

Whereas, Justin Dart is recognized nationally as an advocate who has worked selflessly and without hesitation for the inclusion for all people, regardless of disability, in mainstream society;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 28, 1992, as JUSTIN DART DAY in Illinois and commend him on the dedication he has shown in improving the quality of life for our citizens.

Issued by the Governor January 31, 1992.
Filed with the Secretary of State February 7, 1992.

92-051
SALES AND MARKETING MONTH

Whereas, a fundamental precept of the principles upon which the United States is founded is the free and increasing exchange and distribution of goods and services for the benefit of all people; and

Whereas, the orderly distribution of the output of our companies and corporations is vital to their continuing efficient operation; and

Whereas, sales and marketing professionals are the purveyors of goods that fulfill society's needs and wants, and they are the imaginative developers of markets and ideas for the effective and ever-increasing employment of Illinois citizens and facilities;

Therefore, I, Jim Edgar, Governor of the State of Illinois,

proclaim February 1992 as SALES AND MARKETING MONTH in Illinois, urging all members of the business, labor, agricultural, educational, and civic professions to participate in this observance.

Issued by the Governor January 31, 1992.
Filed with the Secretary of State February 7, 1992.

92-052
COMMONWEALTH EDISON E-TEAM DAY

Whereas, Commonwealth Edison employees and the jobs they perform contribute to the quality of life for Northern Illinois area residents; and

Whereas, Commonwealth Edison's e-Team consists of employee volunteers concerned about the well-being, security, and safety of customers. The e-Team members are willing to go beyond their job descriptions to help customers when possible; and

Whereas, since 1985, e-Team members have assisted Northern Illinois residents in emergency situations;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 18, 1992, as COMMONWEALTH EDISON E-TEAM DAY in Illinois.

Issued by the Governor February 3, 1992.
Filed with the Secretary of State February 7, 1992.

92-053
NAVY WIVES CLUBS OF AMERICA/ 55TH ANNIVERSARY

Whereas, 1992 marks the 55th annversary of the California-chartered Navy Wives Clubs of America; and

Whereas, the organization had been in existence for 5 years and had 36 chapters when World War II began for the United States at Pearl Harbor December 7, 1941. By the end of World War II hostilities in 1945, the organization had grown to include 83 chapters; and

Whereas, Chapter 52 was active at the Naval Training Center of Great Lakes, Illinois, during World War II but was disbanded in 1947 when activities at the center were cut back; and

Whereas, with the advent of the "Cold War" and increased military activity at the Naval Training Center, Chapter 104 was initiated for a new group of enlisted spouses; and

Whereas, Chapter 104 celebrated its 44th year of community service January 3, 1992; and

Whereas, now operating under a federal charter, the name of the worldwide organization must remain as the Navy Wives Clubs of America. However, the membership has expanded to include both male and female spouses of active duty military members from all brances of service and any other people wishing to take part in the support activities;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim 1992 as the 55TH ANNIVERSARY OF THE NAVY WIVES CLUBS OF AMERICA in Illinois, in recognition of the organization's numerous support activities.

Issued by the Governor February 3, 1992.
Filed with the Secretary of State February 7, 1992.

92-054
SCANDINAVIAN WEEK

Whereas, the Scandinavian-American community has proven to be an instrumental contributor to the cultural and educational development of the State of Illinois; and

Whereas, the Scandinavian-American woman will be recognized as the celebrated guest of honor at the second Great Scandinavian Valentine Ball to be held at the Hotel Inter-Continental Chicago; and

Whereas, a combination of cultural, social, and business events, including the Scandinavian Business Forum, will take place during the week prior to the Great Scandinavian Valentine Ball; and

Whereas, recent developments in 'New Europe' emphasize the importance of uniting forces to improve cultural, social and economic understanding between countries; and

Whereas, the Scandinavian Valentine Ball provides an opportunity to share ideas about such unity and celebrates the Scandinavian community's contributions to Chicago;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 12-16, 1992, as SCANDINAVIAN WEEK in Illinois in recognition of the Scandinavian community's contributions to the State of Illinois.

Issued by the Governor February 3, 1992.
Filed with the Secretary of State February 7, 1992.

92-055
ENGINEERS WEEK

Whereas, the engineering community of this state has provided a wealth of innovation in the fields of agriculture, industry, transportation, construction, and education; and

Whereas, increasingly, we must depend upon these professional men and women to find technological solutions to the problems we will face in the future; and

Whereas, in order to emphasize the role of professional engineers in our society, the 1992 theme for National Engineers Week is "Engineers: Turning Ideas Into Reality";

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 16-22, 1992, as ENGINEERS WEEK in Illinois, in conjunction with the national observance and in recognition of the indispensable contributions engineers have made in the past and will continue to make in the future.

Issued by the Governor February 4, 1992.
Filed with the Secretary of State February 7, 1992.

92-056
IVAN ELLIOTT JR. DAY

Whereas, Ivan Elliott Jr. has devoted 24 years of public service to Southern Illinois University at Edwardsville and Illinois higher education, exemplifying the spirit of volunteer action and the essence of citizenship in a democratic society; and

Whereas, Southern Illinois University at Edwardsville recognizes student leadership and citizenship development as integral factors in the overall education of students; and

Whereas, we should emphasize the significance of service to our communities, our nation, and fellow human beings;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 9, 1992, as IVAN ELLIOTT JR DAY in Illinois and urge citizens to be cognizant of the importance of public service and student leadership.

Issued by the Governor February 4, 1992.
Filed with the Secretary of State February 7, 1992.

92-057
JAY B. ROSS DAY

Whereas, Jay B. Ross, nicknamed the rapping lawyer, has practiced entertainment law for more than 20 years; and

Whereas, this year, Jay B. Ross will be celebrating his 50th birthday--the 11th anniversary of his 39th birthday; and

Whereas, a party will be held February 12, 1992, in his honor; and

Whereas, all proceeds from the party will be donated to Variety Club and Chicago Academy of Performing Arts;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 12, 1992, as JAY B. ROSS DAY in Illinois.

Issued by the Governor February 4, 1992.
Filed with the Secretary of State February 7, 1992.

JCAR - Joint Committee on Administrative Rules

ACTION CODES

A – Adopted Rule	*P – Proposed Rule*
AR – Adopted Repealer	*PF – Prohibited Filing Ordered by JCAR*
C – Notice of Corrections	*PP – Peremptory or Court ordered Rules*
CC – Codification Changes	*PR – Proposed Repealer*
E – Emergency Rule	*R – Refusal to meet JCAR objection*
ER – Emergency Repealer	*RC – Statement of Recommendation*
M – Modification to meet JCAR objections	*S – Suspension ordered by JCAR*
O – JCAR Statement of Objections	*W – Withdrawal to meet JCAR objections*

EXAMPLE:

AGRICULTURE, DEPARTMENT OF

8 Ill. Adm. Code 285 Ill. Grain Insurance Act (P-18048/85; A-6818)

TITLE — PART — ACTION CODE — PAGE NUMBER — PAGE NUMBER — ACTION CODE — PREVIOUS VOLUME

ALL RULES ARE LISTED BY PART NUMBER AND HEADING ONLY. (FOR ACTION ON SPECIFIC SECTIONS, PLEASE REFER TO THE SECTIONS AFFECTED INDEX.) IF THERE ARE ANY QUESTIONS, PLEASE CONTACT THE ADMINISTRATIVE CODE DIVISION AT (217) 782-9786.

ABANDONED MINED LANDS RECLAMATION COUNCIL
62 Ill. Adm. Code 2501 Abandoned Mined Lands Reclamation (P-2719) (E-2897)

AGING, DEPARTMENT ON
89 Ill. Adm. Code 240 Community Care Program (E-17398/91; S-1744, W-2955; M-2943) (P-17007/91; PF-1744; M-2930) (E-2630) (E-2901)

AGRICULTURE, DEPARTMENT OF
8 Ill. Adm. Code 125 Meat & Poultry Inspection Act (PP-1899) (P-1921)

ALCOHOLISM AND SUBSTANCE ABUSE, DEPARTMENT OF
4 Ill. Adm. Code 500 Americans With Disabilities Act Grievance Procedure (P-2721)
77 Ill. Adm. Code 2031 Award Criteria & Procedure (P-9149/91; AR-2455)
77 Ill. Adm. Code 2030 Award & Monitoring of Funds (P-9083/91; A-2457)
77 Ill. Adm. Code 2030 Fiscal & Programmatic Requirements (P-9153/91; AR-2530)
77 Ill. Adm. Code 2032 Suspension & Termination of Financial Assistance (P-9218; AR-2533)

ATTORNEY GENERAL
4 Ill. Adm. Code 125 Americans With Disabilities Act Grievance Procedures (P-2283)

CENTRAL MANAGEMENT SERVICES, DEPARTMENT OF
4 Ill. Adm. Code 450 Americans With Disabilities Act Grievance Procedures (P-2292)
80 Ill. Adm. Code 303 Conditions of Employment (P-327)

CENTRAL MANAGEMENT SERVICES, DEPARTMENT OF (CONT'D)
80 Ill. Adm. Code 304 General Provisions (P-334)
80 Ill. Adm. Code 302 Merit & Fitness (P-336)
80 Ill. Adm. Code 310 Pay Plan (P-342) (E-711)

CHILDREN AND FAMILY SERVICES, DEPARTMENT OF
89 Ill. Adm. Code 406 Licensing Standards for Day Care Homes (E-14734/91; M-2269)

COMMERCE AND COMMUNITY AFFAIRS, DEPARTMENT OF
14 Ill. Adm. Code 520 Enterprise Zone Program (P-9787/91; A-89)
47 Ill. Adm. Code 140 Ill. Clean & Beautiful Program (PR-13241/91; AR-2120)
56 Ill. Adm. Code 2630 Uniform Fiscal & Administrative Standards for the Job Training Parnership Act (P-8081/91; A-1524)

COMMERCE COMMISSION, ILLINOIS
92 Ill. Adm. Code 1311 Commodity Group Definitions (P-4195/91; W-2942
83 Ill. Adm. Code 445 Purchase & Sale of Electric Energy from Qualified Solid Waste Energy Facilities (P-11025/91; A-2535)
83 Ill. Adm. Code 200 Rules of Practice (P-1936)
83 Ill. Adm. Code 410 Standards of Service for Electric Utilities (P-11899/91; A-2544)
83 Ill. Adm. Code 500 Standards of Service for Gas Utilities (P-11905/91; A-2550)

CONSERVATION, DEPARTMENT OF
17 Ill. Adm. Code 3035 Boat Access Area Development Program (P-14783/91; A-1797)
17 Ill. Adm. Code 2520 Consignment of Licenses (P-2297)
17 Ill. Adm. Code 2030 Designation of Restricted Waters in the State of Illinois (P-2302)
17 Ill. Adm. Code 590 Duck, Goose & Coot Hunting (P-14157/91; A-570)
17 Ill. Adm. Code 1010 Ill. List of Endangered & Threatened Fauna (P-13594/91; A-103)
17 Ill. Adm. Code 3010 Ill. Snowmobile Grant Program (P-14794/91; A-1806)
17 Ill. Adm. Code 3030 Land & Water Conservation Fund Grant Program (P-14807/91; A-1816)
17 Ill. Adm. Code 525 Nuisance Wildlife Control Permits (P-15647/91; A-1826)
17 Ill. Adm. Code 970 Pigeon Shooting Permits (PR-2727)
17 Ill. Adm. Code 3020 Snowmobile Trail Establishment Fund Grant Program (P-14820/91; A-1833)
17 Ill. Adm. Code 880 Taking of Reptiles & Amphibians, The (P-13603/91; A-109)
17 Ill. Adm. Code 710 Taking of Wild Turkeys-Spring Season, The (P-14833/91; A-1843)
17 Ill. Adm. Code 1538 Urban Foresty Grant Program (P-775)

CORRECTIONS, DEPARTMENT OF
20 Ill. Adm. Code 435 Volunteer Services (P-1941)

CRIMINAL JUSTICE INFORMATION AUTHORITY
20 Ill. Adm. Code 1580 Americans With Disabilities Act Grievance Procedure (P-1948)

EDUCATION, STATE BOARD OF
23 Ill. Adm. Code 130 Determining Special Education Per Capita Tuition Charge (P-1439)
23 Ill. Adm Code 235 Preschool Educational & Coordinated Model Preschool Educational Programs (P-439)
23 Ill. Adm. Code 120 Pupil Transportation Reimbursement (P-1452)

EMPLOYMENT SECURITY, DEPARTMENT OF
56 Ill. Adm. Code 2725 Administrative Hearings & Appeals (P-13252/91; A-113) (P-14014/91; A-2122)
56 Ill. Adm. Code 2720 Claims, Adjudication, Appeals & Hearings (P-14343/91; A-2556)
56 Ill. Adm. Code 2770 Determination of Unemployment Contributions (P-13257/91; A-118)
56 Ill. Adm. Code 2327 Employment (P-785)
56 Ill. Adm. Code 2765 Payment of Unemployment Contributions, Interest & Penalties (P-14032/91; A-2131)

FIRE MARSHAL, OFFICE OF THE STATE
41 Ill. Adm. Code 215 Americans With Disabilities Act Grievance Procedure (P-1954)

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PROCLAMATIONS (CONT'D)

ILLINOIS REGISTER
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PROCLAMATIONS (CONT'D)

The Sections Affected Index lists, by Title, each Section of a codified Part on which rulemaking activity has occurred in this volume of the Register and is divided into two parts: the first lists the Sections on which rulemaking occurred in the previous issues of this volume year; the second lists the Sections on which rulemaking activity occurred in this issue of the Register. (The headings at the top of each page indicate the two parts: the first part shows the previous issue numbers inclusively and the date of the last published issue; the second lists the current issue number and date.) The columns in both parts indicate the type of rulemaking activity and the action taken along with the page number on which the first page of the notice of rulemaking activity appeared. If a Section on which action is being taken in the current volume (calendar year) of the Register was proposed in a previous volume, the last two digits of the previous volume's year appear immediately after the page number separated by a slash. (e.g. 1 Ill. Adm. Code 100.280 was proposed last year and adopted this year. The action entry reads: (P-8577/89; A-724) The codes for both columns are listed below. For a complete listing of the Titles of the *Illinois Administrative Code*, please refer to 1 Ill. Adm. Code 100.140 or contact the Administrative Code Division.

TYPE OF RULEMAKING

am = amendment to existing Section
cc = codification changes
n = new Section
r = repeal of existing Section
rc = recodified
# = renumbered

ACTION CODES

A = Adopted rule
C = Correction
CC = Codification Changes
E = Emergency rule
F = Failure to Remedy Objections
M = Modification
O = JCAR Objection
P = Proposed rule
PF = Prohibited Filing
PP = Peremptory rule
R = Refusal to Modify or Withdraw
RC = JCAR Recommendation
S = Suspended rule
W = Withdrawal of Proposed rule

TITLE 1

245.100	n	(P-2314)
245.110	n	(P-2314)
245.120	n	(P-2314)
245.130	n	(P-2314)
245.140	n	(P-2314)
245.Ex. A	n	(P-2314)
245.Ex. B	n	(P-2314)

TITLE 2

1052.10	n	(P-2322)
1052.20	n	(P-2322)
1052.30	n	(P-2322)
1052.40	n	(P-2322)
1052.50	n	(P-2322)
1052.60	n	(P-2322)
1052.70	n	(P-2322)
1052.80	n	(P-2322)
1052.Ap. A	n	(P-2322)

TITLE 4

125.10	n	(P-2283)
125.20	n	(P-2283)
125.30	n	(P-2283)
125.40	n	(P-2283)
125.50	n	(P-2283)
125.60	n	(P-2283)
125.70	n	(P-2283)
125.80	n	(P-2283)
125.Ap. A	n	(P-2283)
350.110	n	(P-2106)
350.120	n	(P-2106)
350.130	n	(P-2106)
350.140	n	(P-2106)
350.150	n	(P-2106)
350.160	n	(P-2106)
350.170	n	(P-2106)
350.180	n	(P-2106)
450.10	n	(P-2292)
450.20	n	(P-2292)
450.30	n	(P-2292)
450.40	n	(P-2292)
450.50	n	(P-2292)
450.60	n	(P-2292)
450.70	n	(P-2292)
500.1	n	(P-2721)
500.2	n	(P-2721)
500.3	n	(P-2721)
500.4	n	(P-2721)
500.5	n	(P-2721)
500.6	n	(P-2721)
500.7	n	(P-2721)

TITLE 8

125.10	am	(P-1921)
125.190	am	(P-1921)
125.260	am	(PP-1899) (P-1921)
125.270	am	(P-1921)
125.290	am	(P-1921)
125.295	n	(P-1921)
125.380	am	(PP-1899)
125.390	am	(P-1921)

TITLE 11

405.90	am	(P-2436)
415.60	n	(P-1263)
450.10	n	(P-2292)
1305.120	r	(P-2439)
1305.130	r	(P-2439)
1305.140	am	(P-2439)
1314.10	r	(P-2433)
1424.100	r	(P-2444)
1424.170	r	(P-2444)
1424.105	r	(P-2444)
1424.250	am	(P-1266)
1705.10	n	(P-1779)
1705.20	n	(P-1779)
1705.30	n	(P-1779)
1705.40	n	(P-1779)
1705.50	n	(P-1779)
1705.60	n	(P-1779)
1705.70	n	(P-1779)

TITLE 14

520.900	am	(P-89)
520.930	am	(P-89)
520.1100	n	(P-89)
520.1110	n	(P-89)
520.1120	n	(P-89)
520.1130	n	(P-89)
520.1140	n	(P-89)

TITLE 17

525.30	am	(P-15647/91; A-1826)
590.10	am	(P-14157/91; A-570)
590.20	am	(P-14157/91; A-570)
590.60	am	(P-14157/91; A-570)
710.10	am	(P-14833/91; A-1843)
710.20	am	(P-14833/91; A-1843)
710.21	am	(P-14833/91; A-1843)
710.30	am	(P-14833/91; A-1843)
710.50	am	(P-14833/91; A-1843)
880.10	n	(P-13603/91; A-109)
880.20	n	(P-13603/91; A-109)
880.30	n	(P-13603/91; A-109)
880.40	n	(P-13603/91; A-109)
880.50	n	(P-13603/91; A-109)
970.10	r	(P-2727)
970.20	r	(P-2727)
970.30	r	(P-2727)
970.40	r	(P-2727)
970.50	r	(P-2727)
970.60	r	(P-2727)
1010.30	am	(P-13594/91; A-103)
1538.5	n	(P-775)
1538.10	n	(P-775)
1538.20	n	(P-775)
1538.30	n	(P-775)
1538.40	n	(P-775)
1538.50	n	(P-775)
1538.60	n	(P-775)
1538.70	n	(P-775)
1538.80	n	(P-775)
2030.15	am	(P-2302)
2030.20	am	(P-2302)
2300.10	n	(P-2310)

TITLE 17 (CONT'D)

2300.30	n	(P-2310)
2300.50	n	(P-2310)
2300.70	n	(P-2310)
2520.50	am	(P-2297)
3010.40	am	(P-14794/91; A-1806)
3010.50	am	(P-14794/91; A-1806)
3010.70	am	(P-14794/91; A-1806)
3010.80	am	(P-14794/91; A-1806)
3020.20	am	(P-14820/91; A-1833)
3020.40	am	(P-14820/91; A-1833)
3020.50	am	(P-14820/91; A-1833)
3020.70	am	(P-14820/91; A-1833)
3020.80	am	(P-14820/91; A-1833)
3030.30	am	(P-14807/91; A-1816)
3030.50	am	(P-14807/91; A-1816)
3030.60	am	(P-14807/91; A-1816)
3035.40	am	(P-14783/91; A-1797)
3035.70	am	(P-14783/91; A-1797)
3035.80	am	(P-14783/91; A-1797)

TITLE 20

435.10	am	(P-1941)
435.12	n	(P-1941)
435.15	am	(P-1941)
435.20	am	(P-1941)
435.30	am	(P-1941)
435.40	am	(P-1941)
435.50	am	(P-1941)
435.60	am	(P-1941)
435.70	n	(P-1941)
1235.10	n	(E-17785/91; O-1746)
1235.20	n	(E-17785/91; O-1746)
1235.30	n	(E-17785/91; O-1746)
1235.40	n	(E-17785/91; O-1746)
1235.50	n	(E-17785/91; O-1746)
1235.60	n	(E-17785/91; O-1746)
1235.70	n	(E-17785/91; O-1746)
1235.80	n	(E-17785/91; O-1746)
1235.90	n	(E-17785/91; O-1746)
1235.100	n	(E-17785/91; O-1746)
1235.110	n	(E-17785/91; O-1746)
1235.120	n	(E-17785/91; O-1746)
1235.130	n	(E-17785/91; O-1746)
1570.10	n	(P-2732)
1570.20	n	(P-2732)
1570.30	n	(P-2732)
1570.40	n	(P-2732)
1570.50	n	(P-2732)
1570.60	n	(P-2732)
1580.10	n	(P-1948)
1580.20	n	(P-1948)
1580.30	n	(P-1948)
1580.40	n	(P-1948)
1580.50	n	(P-1948)
1720.35	n	(E-727)
1800.10	n	(P-10)
1800.20	n	(P-10)
1800.30	n	(P-10)
1800.40	n	(P-10)
1810.100	n	(P-469) (E-732)
1810.110	n	(P-469) (E-732)
1810.200	n	(P-469) (E-732)
1810.210	n	(P-469) (E-732)
1810.220	n	(P-469) (E-732)
1810.230	n	(P-469) (E-732)
1810.240	n	(P-469) (E-732)
1810.250	n	(P-469) (E-732)
1810.300	n	(P-469) (E-732)
1810.400	n	(P-469) (E-732)
1810.410	n	(P-469) (E-732)
1810.420	n	(P-469) (E-732)
1810.430	n	(P-469) (E-732)
1810.440	n	(P-469) (E-732)
1810.500	n	(P-469) (E-732)
1810.510	n	(P-469) (E-732)
1810.520	n	(P-469) (E-732)
1810.530	n	(P-469) (E-732)
1810.540	n	(P-469) (E-732)
1810.550	n	(P-469) (E-732)
1810.600	n	(P-469) (E-732)
1810.610	n	(P-469) (E-732)
1810.620	n	(P-469) (E-732)
1810.700	n	(P-469) (E-732)
1810.710	n	(P-469) (E-732)
1810.720	n	(P-469) (E-732)
1810.730	n	(P-469) (E-732)
1810.800	n	(P-469) (E-732)
1810.900	n	(P-469) (E-732)
1810.910	n	(P-469) (E-732)
1810.1000	n	(P-469) (E-732)
1810.1010	n	(P-469) (E-732)
1810.1020	n	(P-469) (E-732)
1810.1100	n	(P-469) (E-732)
1810.1110	n	(P-469) (E-732)

TITLE 23

120.10	am	(P-1452)
120.30	am	(P-1452)
120.40	am	(P-1452)
120.50	am	(P-1452)
120.60	am	(P-1452)
120.90	am	(P-1452)
130.10	am	(P-1439)
130.20	am	(P-1439)
130.30	am	(P-1439)
130.40	am	(P-1439)
130.45	n	(P-1439)
130.50	am	(P-1439)
235.10	n	(P-439)
235.20	n	(P-439)
235.30	n	(P-439)
235.40	n	(P-439)
235.45	n	(P-439)
235.50	n	(P-439)
235.60	n	(P-439)
235.100	n	(P-439)
235.110	n	(P-439)
235.120	n	(P-439)
235.130	n	(P-439)
235.135	n	(P-439)
235.140	n	(P-439)
235.150	n	(P-439)

TITLE 32

210.10	n	(P-2003)

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210.20	n	(P-2003)
210.30	n	(P-2003)
210.40	n	(P-2003)
210.50	n	(P-2003)
210.60	n	(P-2003)
210.70	n	(P-2003)
340.4010	am	(P-2746)
400.120	am	(P-2739)
400.140	am	(P-2739)
400.150	am	(P-2739)
400.160	am	(P-2739)
401.70	am	(P-1474)
401.110	am	(P-1474)
401.130	am	(P-1474)
401.140	am	(P-1474)
401.150	am	(P-1474)
401.160	n	(P-1474)
401.Ap. B	am	(P-1474)
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212.424	am	(P-41)
212.443	am	(P-41)
212.445	am	(P-41)
243.108	am	(P-16)
243.120	n	(P-16)
243.121	r	(P-16)
244.101	am	(P-22)
244.106	am	(P-22)
244.107	am	(P-22)
244.121	am	(P-22)
244.161	am	(P-22)
244.162	am	(P-22)
244.163	am	(P-22)
244.166	am	(P-22)
244.167	am	(P-22)
244.168	am	(P-22)
244.169	am	(P-22)
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601.105	am	(P-9829/91; O-17792/91; R-1713; A-1585)
615.101	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.102	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.103	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.104	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.105	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.201	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.202	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.203	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.204	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.205	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.206	n	(P-10303/91; O-17791/91 R-1702; A-1538)
615.207	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.208	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.209	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.210	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.211	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.301	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.302	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.303	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.304	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.305	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.306	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.307	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.401	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.402	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.403	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.404	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.421	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.422	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.423	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.424	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.425	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.441	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.442	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.443	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.444	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.445	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.446	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.447	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.461	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.462	n	(P-10303/91; O-17791/91; R-1702; A-1538)

TITLE 35 (CONT'D)

615.463	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.464	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.501	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.502	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.601	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.602	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.603	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.604	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.621	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.622	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.623	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.624	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.701	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.702	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.703	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.704	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.705	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.721	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.722	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.723	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.724	n	(P-10303/91; O-17791/91; R-1702; A-1538)
616.101	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.102	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.104	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.105	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.201	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.202	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.203	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.204	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.205	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.206	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.207	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.208	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.209	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.210	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.211	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.301	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.302	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.304	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.305	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.306	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.307	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.401	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.402	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.421	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.422	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.423	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.424	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.425	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.441	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.442	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.443	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.444	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.445	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.446	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.447	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.461	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.462	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.463	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.464	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.501	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.502	n	(P-9836/91; O-17793/91; R-1723; A-1592)

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616.601	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.602	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.603	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.604	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.605	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.621	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.622	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.623	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.624	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.625	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.701	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.702	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.703	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.704	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.705	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.721	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.722	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.723	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.724	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.725	n	(P-9836/91; O-17793/91; R-1723; A-1592)
617.101	n	(P-9882/91; O-17794/91; R-1734; A-1639)
617.102	n	(P-9882/91; O-17794/91; R-1734; A-1639)
703.150	am	(P-1058)
703.155	am	(P-1058)
703.157	am	(P-1058)
703.208	n	(P-1058)
703.211	am	(P-1058)
703.232	n	(P-1058)
703.280	am	(P-1058)
703.283	am	(P-1058)
703.Ap. A	am	(P-1058)
720.110	am	(P-791)
720.111	am	(P-791)
721.102	am	(P-820)
721.103	am	(P-820)
721.104	am	(P-820)
721.106	am	(P-820)
721.120	am	(P-820)
721.131	am	(P-820) (P-15910/91; A-2600)
721.132	am	(P-820)
721.Ap. I	am	(P-9288/91; A-2155)
Tb. A	am	(P-9288/91; A-2155)
Tb. B	am	(P-9288/91; A-2155)
722.110	am	(P-1112)
720.134	am	(P-1112)
724.212	am	(P-1123)
724.440	am	(P-1123)
724.930	am	(P-1123)
724.935	am	(P-1123)
725.113	am	(P-875)
725.173	am	(P-875)
725.212	am	(P-875)
725.213	am	(P-875)
725.440	am	(P-875)
725.470	am	(P-875)
725.935	am	(P-875)
725.952	am	(P-875)
726.130	r	(P-1148)
726.131	r	(P-1148)
726.132	r	(P-1148)
726.133	r	(P-1148)
726.134	r	(P-1148)
726.135	r	(P-1148)
726.140	am	(P-1148)
726.200	n	(P-1148)
726.201	n	(P-1148)
726.202	n	(P-1148)
726.203	n	(P-1148)
726.204	n	(P-1148)
726.205	n	(P-1148)
726.206	n	(P-1148)
726.207	n	(P-1148)
726.208	n	(P-1148)
726.209	n	(P-1148)
726.210	n	(P-1148)
726.211	n	(P-1148)
726.212	n	(P-1148)
726.219	n	(P-1148)
726.Ap. A	n	(P-1148)
726.Ap. B	n	(P-1148)
726.Ap. C	n	(P-1148)
726.Ap. D	n	(P-1148)
726.Ap. E	n	(P-1148)
726.Ap. F	n	(P-1148)
726.Ap. G	n	(P-1148)
726.Ap. H	n	(P-1148)
726.Ap. I	n	(P-1148)
726.Ap. J	n	(P-1148)
726.Ap. K	n	(P-1148)
726.Ap. L	n	(P-1148)
726.Tb. A	n	(P-1148)
728.107	am	(P-916)
728.109	am	(P-916)
728.110	n	(P-916)
728.111	n	(P-916)
728.112	n	(P-916)
728.113	n	(P-916)
728.133	am	(P-916)
728.135	am	(P-916)
728.140	am	(P-916)
728.142	am	(P-916)
728.144	am	(P-916)
728.Ap. D	am	(P-916)

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728.Ap. E	am	(P-916)
728.Ap. G	am	(P-916)
728.Ap. H	am	(P-916)
728.Ap. I	n	(P-916)
728.Tb. A	am	(P-916)
728.Tb. B	am	(P-916)
728.Tb. C	am	(P-916)
728.Tb. D	am	(P-916)
728.Tb. E	am	(P-916)
731.110	am	(P-2330)
731.111	r	(P-2330)
731.112	am	(P-2330)
731.11[illegible]	am	(P-2330)
731.11[illegible]	r	(P-2330)
731.120	r	(P-2330)
731.121	r	(P-2330)
731.122	am	(P-2330)
731.130	r	(P-2330)
731.131	r	(P-2330)
731.132	r	(P-2330)
731.133	r	(P-2330)
731.134	r	(P-2330)
731.140	r	(P-2330)
731.141	r	(P-2330)
731.142	r	(P-2330)
731.143	r	(P-2330)
731.144	r	(P-2330)
731.145	r	(P-2330)
731.150	r	(P-2330)
731.151	r	(P-2330)
731.152	r	(P-2330)
731.153	r	(P-2330)
731.161	am	(P-2330)
731.162	am	(P-2330)
731.170	r	(P-2330)
731.171	r	(P-2330)
731.172	r	(P-2330)
731.173	r	(P-2330)
731.174	r	(P-2330)
731.190	r	(P-2330)
731.191	r	(P-2330)
731.192	r	(P-2330)
731.193	r	(P-2330)
731.194	r	(P-2330)
731.195	r	(P-2330)
731.196	r	(P-2330)
731.197	r	(P-2330)
731.198	r	(P-2330)
731.199	r	(P-2330)
731.200	r	(P-2330)
731.202	r	(P-2330)
731.203	r	(P-2330)
731.204	r	(P-2330)
731.205	r	(P-2330)
731.206	r	(P-2330)
731.207	r	(P-2330)
731.208	r	(P-2330)
731.209	r	(P-2330)
731.210	r	(P-2330)
731.211	r	(P-2330)
731.Ap. A	am	(P-2330)
731.Ap. C	n	(P-2330)
809.901	r	(P-13017/91; A-130)
809.902	r	(P-13017/91; A-130)
809.903	r	(P-13017/91; A-130)
809.904	r	(P-13017/91; A-130)
809.905	r	(P-13017/91; A-130)
809.906	r	(P-13017/91; A-130)
849.101	r	(P-13265/91; A-2880)
849.102	r	(P-13265/91; A-2880)
849.103	r	(P-13265/91; A-2880)
849.104	r	(P-13265/91; A-2880)
849.105	r	(P-13265/91; A-2880)
849.106	r	(P-13265/91; A-2880)
1420.101	n	(P-17016/91; A-2594)
1420.102	n	(P-17016/91; A-2594)

TITLE 38

450.440	am	(P-2763) (E-2915)
450.1010	am	(P-2763) (E-2915)
450.1250	am	(P-2763) (E-2915)
450.1335	am	(P-2763) (E-2915)
450.1340	am	(P-2763) (E-2915)

TITLE 41

215.1	n	(P-1954)
215.2	n	(P-1954)
215.20	n	(P-1954)
215.30	n	(P-1954)
215.50	n	(P-1954)
215.60	n	(P-1954)
215.70	n	(P-1954)

TITLE 47

140.10	r	(P-13241/91; A-2120)
140.20	r	(P-13241/91; A-2120)
140.30	r	(P-13241/91; A-2120)
140.40	r	(P-13241/91; A-2120)
140.50	r	(P-13241/91; A-2120)
140.60	r	(P-13241/91; A-2120)
310.101	am	(P-1961)
310.102	am	(P-1961)
310.103	am	(P-1961)
310.106	am	(P-1961)
310.107	am	(P-1961)
310.109	am	(P-1961)
310.110	am	(P-1961)
310.111	am	(P-1961)
310.113	am	(P-1961)
310.114	am	(P-1961)
310.201	am	(P-1961)
310.202	am	(P-1961)
310.203	am	(P-1961)
310.204	am	(P-1961)
310.205	am	(P-1961)
310.206	am	(P-1961)
310.301	am	(P-1961)
310.302	am	(P-1961)
310.303	am	(P-1961)
310.304	am	(P-1961)
310.305	am	(P-1961)
310.306	am	(P-1961)
310.307	am	(P-1961)
310.308	am	(P-1961)
310.309	am	(P-1961)

TITLE 47 (CONT'D)

310.401	am	(P-1961)
310.402	am	(P-1961)
310.403	am	(P-1961)
310.404	am	(P-1961)
310.405	am	(P-1961)
310.602	am	(P-1961)
310.603	am	(P-1961)
310.604	am	(P-1961)
310.701	am	(P-1961)
310.702	am	(P-1961)
310.703	am	(P-1961)
310.801	am	(P-1961)
310.802	am	(P-1961)
310.803	am	(P-1961)
310.804	am	(P-1961)
310.805	am	(P-1961)
310.806	am	(P-1961)
310.901	am	(P-1961)
310.902	am	(P-1961)
310.913	am	(P-1961)

TITLE 50

2008.10	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.20	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.30	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.40	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.50	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.60	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.61	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.70	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.71	#	(P-14859/91; PF-1743; W-2956; A-2766)
2008.71	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.72	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.73	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.74	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.75	#	(P-14859/91; PF-1743; W-2956; A-2766)
2008.75	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.80	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.81	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.81	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.82	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.90	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.100	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.101	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.102	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.103	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.104	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.110	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. A	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. B	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. C	#	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. C	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. D	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. D	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. E	#	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. E	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. F	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. G	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. H	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. I	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. J	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. K	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. L	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. M	#	(P-14859/91; PF-1743; W-2956; A-2766
2008.Ap. M	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. N	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. N	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. O	#	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. O	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. P	n	(P-14859/91; PF-1743; W-2956; A-2766)
3119.40	am	(P-11055/91; A-126)

TITLE 56

120.100	n	(P-1997)
120.110	n	(P-1997)
120.120	n	(P-1997)
120.130	n	(P-1997)

TITLE 56 (CONT'D)

120.140	n	(P-1997)
120.150	n	(P-1997)
120.160	n	(P-1997)
120.170	n	(P-1997)
350.10	am	(P-1)
350.280	am	(P-1)
1700.10	n	(P-1469)
1700.20	n	(P-1469)
1700.30	n	(P-1469)
1700.40	n	(P-1469)
1700.50	n	(P-1469)
1700.60	n	(P-1469)
2630.82	am	(P-8081/91; A-1524)
2630.83	am	(P-8081/91; A-1524)
2720.1	am	(P-14343/91; A-2556)
2720.5	am	(P-14343/91; A-2556)
2720.7	am	(P-14343/91; A-2556)
2720.10	am	(P-14343/91; A-2556)
2720.108	am	(P-14343/91; A-2556)
2720.130	am	(P-14343/91; A-2556)
2720.215	am	(P-14343/91; A-2556)
2720.240	am	(P-14343/91; A-2556)
2720.315	am	(P-14343/91; A-2556)
2725.105	am	(P-14014/91; A-2122)
2725.115	am	(P-14014/91; A-2122)
2725.237	n	(P-13252/91; A-113)
2732.305	n	(P-785)
2765.45	am	(P-14032/91; A-2131)
2765.55	am	(P-14032/91; A-2131)
2765.60	am	(P-14032/91; A-2131)
2765.68	am	(P-14032/91; A-2131)
2770.110	am	(P-13257/91; A-118)
5400.110	am	(P-1490) (E-1693)
5400.210	am	(P-1490) (E-1693)
5400.310	am	(P-1490) (E-1693)

TITLE 59

101.100	n	(P-14363/91; A-2137) (E-14663/91)
103.90	am	(E-2643)
115.300	am	(P-18334/91)
115.320	am	(E-2676)
119.260	am	(E-2662)
120.70	am	(E-2652)
125.70	am	(E-2672)
130.110	am	(E-2656)
132.10	n	(P-7) (E-211)
132.15	n	(P-7) (E-211)
132.20	n	(P-7) (E-211)
132.25	n	(P-7) (E-211)
132.30	n	(P-7) (E-211)
132.35	n	(P-7) (E-211)
132.40	n	(P-7) (E-211)
132.45	n	(P-7) (E-211)
132.50	n	(P-7) (E-211)
132.55	n	(P-7) (E-211)
132.60	n	(P-7) (E-211)
132.65	n	(P-7) (E-211)
132.70	n	(P-7) (E-211)
132.75	n	(P-7) (E-211)
132.80	n	(P-7) (E-211)
132.85	n	(P-7) (E-211)
132.90	n	(P-7) (E-211)
132.95	n	(P-7) (E-211)
132.100	n	(P-7) (E-211)
132.105	n	(P-7) (E-211)
132.110	n	(P-7) (E-211)
132.115	n	(P-7) (E-211)
132.120	n	(P-7) (E-211)
132.125	n	(P-7) (E-211)
132.130	n	(P-7) (E-211)
132.135	n	(P-7) (E-211)
132.140	n	(P-7) (E-211)
132.145	n	(P-7) (E-211)
132.150	n	(P-7) (E-211)
132.155	n	(P-7) (E-211)
132.160	n	(P-7) (E-211)
132.165	n	(P-7) (E-211)
132.170	n	(P-7) (E-211)
132.Ap.A	n	(P-7) (E-211)
132.Ap.B	n	(P-7) (E-211)
Tb. A	n	(P-7) (E-211)
Tb. B	n	(P-7) (E-211)
Tb. C	n	(P-7) (E-211)
135.30	am	(E-2648)

TITLE 62

240.995	r	(P-14365/91; A-2576) (E-14679)]
240.1400	r	(P-14365/91; A-2576) (E-14679)
240.1405	r	(P-14365/91; A-2576) (E-14679)
240.1410	r	(P-14365/91; A-2576) (E-14679)
240.1420	r	(P-14365/91; A-2576) (E-14679)
240.1430	r	(P-14365/91; A-2576) (E-14679)
240.1440	r	(P-14365/91; A-2576) (E-14679)
240.1450	r	(P-14365/91; A-2576) (E-14679)
240.1460	r	(P-14365/91; A-2576) (E-14679)
240.1470	r	(P-14365/91; A-2576) (E-14679)
240.1500	r	(P-14365/91; A-2576) (E-14679)
240.1510	r	(P-14365/91; A-2576) (E-14679)
240.1520	r	(P-14365/91; A-2576) (E-14679)
240.1530	r	(P-14365/91; A-2576) (E-14679)
2501.37	n	(P-2719) (E-2897)

TITLE 68

1130.10	n	(P-2010)
1130.20	n	(P-2010)
1130.30	n	(P-2010)
1130.40	n	(P-2010)
1130.50	n	(P-2010)
1130.60	n	(P-2010)
1130.70	n	(P-2010)

TITLE 71

2000.45	am	(P-1511)
2000.100	am	(P-1511)
2000.210	am	(P-1511)
2000.245	am	(P-1511)
2000.250	am	(P-1511)
2000.320	am	(P-1511)
2000.340	am	(P-1511)
2000.410	am	(P-1511)
2000.430	am	(P-1511)
2000.500	am	(P-1511)
2000.520	am	(P-1511)
2000.540	am	(P-1511)

TITLE 74

750.40	am	(P-15035/91; A-203)
750.Ap. B	am	(P-15035/91; A-203)
750.Ap. C	n	(P-15035/91; A-203)

TITLE 77

250.2720	n	(P-2016)
300.110	am	(P-2034)
300.120	am	(P-4367/91; A-681)
300.140	am	(P-2034)
300.150	am	(P-2034)
300.330	am	(P-4367/91; A-681) (P-2034)
300.620	am	(P-4367/91; A-681)
300.630	am	(P-2034)
300.1010	am	(P-2034)
300.1220	am	(P-2034)
300.1240	am	(P-2034)
300.2070	am	(P-2034)
300.3060	am	(P-2034)
300.3100	am	(P-2034)
300.3310	am	(P-2034)
300.3710	am	(P-2034)
300.Ap. B	r	(P-2034)
330.120	am	(P-4338/91; A-651)
330.330	am	(P-4338/91; A-651)
350.120	am	(P-4280/91; A-594)
350.330	am	(P-4280/91; A-594)
390.120	am	(P-4309/91; A-623)
390.330	am	(P-4309/91; A-623)
830.10	am	(P-2092)
830.880	am	(P-2092)
830.885	am	(P-2092)
830.890	am	(P-2092)
830.900	am	(P-2092)
2030.10	n	(P-9083/91; A-2457)
2030.10	r	(P-9153/91; A-2530)
2030.20	n	(P-9083/91; A-2457)
2030.20	r	(P-9153/91; A-2530)
2030.30	n	(P-9083/91; A-2457)
2030.30	r	(P-9153/91; A-2530)
2030.40	n	(P-9083/91; A-2457)
2030.40	r	(P-9153/91; A-2530)
2030.50	r	(P-9153/91; A-2530)
2030.100	n	(P-9083/91; A-2457)
2030.105	n	(P-9083/91; A-2457)
2030.107	n	(P-9083/91; A-2457)
2030.110	n	(P-9083/91; A-2457)
2030.110	r	(P-9153/91; A-2530)
2030.115	n	(P-9083/91; A-2457)
2030.120	n	(P-9083/91; A-2457)
2030.120	r	(P-9153/91; A-2530)
2030.130	n	(P-9083/91; A-2457)
2030.130	r	(P-9153/91; A-2530)
2030.140	n	(P-9083/91; A-2457)
2030.150	n	(P-9083/91; A-2457)
2030.160	n	(P-9083/91; A-2457)
2030.210	n	(P-9083/91; A-2457)
2030.210	r	(P-9153/91; A-2530)
2030.220	n	(P-9083/91; A-2457)
2030.220	r	(P-9153/91; A-2530)
2030.230	n	(P-9083/91; A-2457)
2030.230	r	(P-9153/91; A-2530)
2030.310	n	(P-9083/91; A-2457)
2030.310	r	(P-9153/91; A-2530)
2030.320	n	(P-9083/91; A-2457)
2030.320	r	(P-9153/91; A-2530)
2030.330	n	(P-9083/91; A-2457)
2030.330	r	(P-9153/91; A-2530)
2030.340	n	(P-9083/91; A-2457)
2030.340	r	(P-9153/91; A-2530)
2030.350	n	(P-9083/91; A-2457)
2030.350	r	(P-9153/91; A-2530)
2030.360	n	(P-9083/91; A-2457)
2030.410	n	(P-9083/91; A-2457)
2030.410	r	(P-9153/91; A-2530)
2030.420	n	(P-9083/91; A-2457)
2030.420	r	(P-9153/91; A-2530)
2030.430	n	(P-9083/91; A-2457)
2030.430	r	(P-9153/91; A-2530)
2030.440	n	(P-9083/91; A-2457)
2030.440	r	(P-9153/91; A-2530)
2030.450	n	(P-9083/91; A-2457)
2030.450	r	(P-9153/91; A-2530)
2030.510	n	(P-9083/91; A-2457)
2030.510	r	(P-9153/91; A-2530)
2030.520	n	(P-9083/91; A-2457)
2030.520	r	(P-9153/91; A-2530)
2030.530	n	(P-9083/91; A-2457)
2030.540	n	(P-9083/91; A-2457)
2030.550	n	(P-9083/91; A-2457)
2030.610	n	(P-9083/91; A-2457)
2030.610	r	(P-9153/91; A-2530)
2030.620	n	(P-9083/91; A-2457)
2030.620	r	(P-9153/91; A-2530)
2030.630	r	(P-9153/91; A-2530)
2030.640	r	(P-9153/91; A-2530)
2030.710	n	(P-9083/91; A-2457)
2030.710	r	(P-9153/91; A-2530)
2030.720	n	(P-9083/91; A-2457)
2030.720	r	(P-9153/91; A-2530)
2030.730	n	(P-9083/91; A-2457)
2030.730	r	(P-9153/91; A-2530)
2030.740	n	(P-9083/91; A-2457)
2030.740	r	(P-9153/91; A-2530)
2030.750	n	(P-9083/91; A-2457)
2030.750	r	(P-9153/91; A-2530)
2030.760	n	(P-9083/91; A-2457)
2030.760	r	(P-9153/91; A-2530)
2030.810	n	(P-9083/91; A-2457)
2030.810	r	(P-9153/91; A-2530)

TITLE 77 (CONT'D)

2030.820	n	(P-9083/91; A-2457)
2030.820	r	(P-9153/91; A-2530)
2030.830	n	(P-9083/91; A-2457)
2030.840	n	(P-9083/91; A-2457)
2030.850	n	(P-9083/91; A-2457)
2030.910	n	(P-9083/91; A-2457)
2030.910	r	(P-9153/91; A-2530)
2030.920	r	(P-9153/91; A-2530)
2030.930	r	(P-9153/91; A-2530)
2030.940	r	(P-9153/91; A-2530)
2030.950	r	(P-9153/91; A-2530)
2030.960	r	(P-9153/91; A-2530)
2030.970	r	(P-9153/91; A-2530)
2030.980	r	(P-9153/91; A-2530)
2030.1010	n	(P-9083/91; A-2457)
2030.1010	r	(P-9153/91; A-2530)
2030.1020	n	(P-9083/91; A-2457)
2030.1020	r	(P-9153/91; A-2530)
2030.1030	n	(P-9083/91; A-2457)
2030.1030	r	(P-9153/91; A-2530)
2030.1040	n	(P-9083/91; A-2457)
2030.1040	r	(P-9153/91; A-2530)
2030.1050	n	(P-9083/91; A-2457)
2030.1060	n	(P-9083/91; A-2457)
2030.1070	n	(P-9083/91; A-2457)
2030.1080	n	(P-9083/91; A-2457)
2030.1090	n	(P-9083/91; A-2457)
2030.1110	n	(P-9083/91; A-2457)
2030.1110	r	(P-9153/91; A-2530)
2030.1120	n	(P-9083/91; A-2457)
2030.1120	r	(P-9153/91; A-2530)
2030.1130	n	(P-9083/91; A-2457)
2030.1130	r	(P-9153/91; A-2530)
2030.1140	r	(P-9153/91; A-2530)
2030.1150	n	(P-9083/91; A-2457)
2030.1160	n	(P-9083/91; A-2457)
2030.1205	n	(P-9083/91; A-2457)
2030.1210	n	(P-9083/91; A-2457)
2030.1210	r	(P-9153/91; A-2530)
2030.1220	r	(P-9153/91; A-2530)
2030.1230	r	(P-9153/91; A-2530)
2030.1240	r	(P-9153/91; A-2530)
2030.1250	r	(P-9153/91; A-2530)
2030.1260	r	(P-9153/91; A-2530)
2030.1270	r	(P-9153/91; A-2530)
2030.1215	n	(P-9083/91; A-2457)
2030.1220	n	(P-9083/91; A-2457)
2030.1225	n	(P-9083/91; A-2457)
2030.1230	n	(P-9083/91; A-2457)
2030.1245	n	(P-9083/91; A-2457)
2030.1250	n	(P-9083/91; A-2457)
2030.1255	n	(P-9083/91; A-2457)
2030.1265	n	(P-9083/91; A-2457)
2030.1310	n	(P-9083/91; A-2457)
2030.1310	r	(P-9153/91; A-2530)
2030.1320	n	(P-9083/91; A-2457)
2030.1320	r	(P-9153/91; A-2530)
2030.1330	r	(P-9153/91; A-2530)
2030.1340	r	(P-9153/91; A-2530)
2030.1350	r	(P-9153/91; A-2530)
2031.10	r	(P-9149/91; A-2455)
2032.15	r	P-9218/91; A-2533)
2032.20	r	P-9218/91; A-2533)
2032.25	r	P-9218/91; A-2533)
2032.30	r	P-9218/91; A-2533)
2032.35	r	P-9218/91; A-2533)
2032.40	r	P-9218/91; A-2533)
2032.45	r	P-9218/91; A-2533)
2032.50	r	P-9218/91; A-2533)
2032.55	r	P-9218/91; A-2533)
2032.60	r	P-9218/91; A-2533)

TITLE 80

302.80	am	(P-336)
303.102	am	(P-327)
303.115	n	(P-327)
303.125	am	(P-327)
303.175	n	(P-327)
303.290	am	(P-327)
303.385	n	(P-327)
304.51	n	(P-334)
310.100	am	(P-342) (E-711)
310.230	am	(P-342)
310.490	am	(P-342) (E-711)
310.Ap. A Tb. C	am	(P-342)
310.Tb. E	am	(P-342)
310.Tb. F	am	(P-342)
310.Tb. G	am	(P-342)
310.Tb. H	am	(P-342)
310.Tb. I	am	(P-342)
310.Tb. J	am	(P-342)
310.Tb. K	am	(P-342)
310.Tb. O	am	(P-342)
310.Tb. P	am	(P-342)
310.Tb. Q	am	(P-342)
310.Tb. R	am	(P-342)
310.Tb. S	am	(P-342)
310.Tb. W	am	(P-342)
310.Tb. X	am	(P-342)
310.Tb. Y	am	(P-342)
310.Tb. Z	am	(P-342)

TITLE 83

200.715	n	(P-1936)
410.360	r	(P-11899/91; A-2544)
445.40	am	(P-11025/91; A-2535)
445.50	am	(P-11025/91; A-2535)
445.70	am	(P-11025/91; A-2535)
500.335	r	(P-11905/91; A-2550)

TITLE 86

110.190	n	(P-14196/91; A-2624)
130.310	am	(P-15013/91; A-1642)

TITLE 89

104.206	am	(P-2752)
104.208	am	(P-2752)
104.210	am	(P-2752)
104.272	am	(P-2752)
104.273	am	(P-2752)
104.274	am	(P-2752)
120.50	r	(P-12137/91; A-139)
120.200	r	(P-12137/91; A-139)
120.208	r	(P-12137/91; A-139)

TITLE 89 (CONT'D)

120.210	r	(P-12137/91; A-139)
120.211	r	(P-12137/91; A-139)
120.212	r	(P-12137/91; A-139)
120.215	r	(P-12137/91; A-139)
120.216	r	(P-12137/91; A-139)
120.217	r	(P-12137/91; A-139)
120.218	r	(P-12137/91; A-139)
120.224	r	(P-12137/91; A-139)
120.225	r	(P-12137/91; A-139)
120.230	r	(P-12137/91; A-139)
120.235	r	(P-12137/91; A-139)
120.236	r	(P-12137/91; A-139)
120.240	r	(P-12137/91; A-139)
120.245	r	(P-12137/91; A-139)
120.250	r	(P-12137/91; A-139)
120.255	r	(P-12137/91; A-139)
120.260	r	(P-12137/91; A-139)
120.261	r	(P-12137/91; A-139)
120.262	r	(P-12137/91; A-139)
120.270	r	(P-12137/91; A-139)
120.271	r	(P-12137/91; A-139)
120.272	r	(P-12137/91; A-139)
120.273	r	(P-12137/91; A-139)
120.275	r	(P-12137/91; A-139)
120.276	r	(P-12137/91; A-139)
120.280	r	(P-12137/91; A-139)
120.281	r	(P-12137/91; A-139)
120.282	r	(P-12137/91; A-139)
120.283	r	(P-12137/91; A-139)
120.284	r	(P-12137/91; A-139)
120.285	r	(P-12137/91; A-139)
120.290	r	(P-12137/91; A-139)
120.295	r	(P-12137/91; A-139)
120.319	am	(P-833/91; A-1862)
120.320	am	(P-833/91; A-1862)
120.321	am	(P-833/91; A-1862)
120.322	am	(P-833/91; A-1862)
120.323	am	(P-833/91; A-1862)
121.58	am	(P-2420)
121.63	am	(E-757)
121.72	am	(P-2420)
121.73	am	(P-2420)
140.2	am	(P-17171/91; A-174)
140.5	am	(P-17171/91; A-174)
140.27	am	(P-65) (E-300)
140.526	r	(P-472)
140.527	r	(P-472)
140.528	r	(P-472)
140.529	r	(P-472)
140.539	am	(P-472)
140.565	n	(P-1492)
140.600	n	(P-472)
140.602	n	(P-472)
140.604	n	(P-472)
140.606	n	(P-472)
140.608	n	(P-472)
140.610	n	(P-472)
140.612	n	(P-472)
140.614	n	(P-472)
140.646	am	(P-6949/91; A-1877)
148.140	am	(P-1786)
150.10	n	(E-2258)
150.20	n	(E-2258)
150.30	n	(E-2258)
150.40	n	(E-2258)
150.50	n	(E-2258)
150.60	n	(E-2258)
160.5	am	(P-806/91; A-1852)
160.10	am	(P-806/91; A-1852)
160.20	am	(P-806/91; A-1852)
160.30	am	(P-2406)
240.400	am	(E-2630)
240.415	am	(E-2630)
240.430	am	(P-17007/91;M-2930) (E-17398/91; S-1744, W-2955; M-2943)
240.435	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943)
240.720	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943) (E-2901)
240.725	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943) (E-2901)
240.726	n	(E-2630)
240.800	am	(E-2901)
240.810	am	(E-2901)
240.825	am	(E-2901)
240.855	am	(E-2901)
406.2	am	(P-14734/91) (E-15088/91; M-2269)
510.10	am	(P-69)
510.20	am	(P-69)
510.30	am	(P-69)
510.40	am	(P-69)
510.70	am	(P-69)
510.80	am	(P-69)
510.90	am	(P-69)
510.100	am	(P-69)
510.110	am	(P-69)
674.10	n	(E-2690)
674.20	n	(E-2690)
674.30	n	(E-2690)
674.40	n	(E-2690)
674.50	n	(E-2690)
683.100	r	(E-2688)
845.10	am	(P-11572/91; A-2615)
845.20	am	(P-11572/91; A-2615)
845.30	am	(P-11572/91; A-2615)
845.40	am	(P-11572/91; A-2615)

TITLE 92

171.6	am	(P-15995/91; W-2696)
171.1000	am	(P-15995/91; W-2696)
172.2000	am	(P-16003/91; W-2697)
172.2215	am	(P-16003/91; W-2697)
173.3000	am	(P-16008/91; W-2698)
177.2000	am	(P-15990/91; W-2695)
178.336.1.1	am	(P-16015/91; W-2699)
178.336.1.5	am	(P-16015/91; W-2699)
178.336.2000	am	(P-16015/91; W-2699)
179.2000	am	(P-16027/91; W-2700)
440.420	am	(P-13041/91; A-1655)
440.Il. A	am	(P-13041/91; A-1655)

TITLE 92 (CONT'D)

440.11. B	n	(P-13041/91; A-1655)
442.285	am	(P-13072/91; A-1685)
442.11. A	am	(P-13072/91; A-1685)
442.11. E	n	(P-13072/91; A-1685)
530.10	n	(P-2940/91; A-2193)
530.10	r	(P-2940/91; A-2193)
530.20	n	(P-2940/91; A-2193)
530.20	r	(P-2940/91; A-2193)
530.30	n	(P-2940/91; A-2193)
530.30	r	(P-2940/91; A-2193)
530.40	n	(P-2940/91; A-2193)
530.50	n	(P-2940/91; A-2193)
530.60	n	(P-2940/91; A-2193)
530.100	n	(P-2940/91; A-2193)
530.101	r	(P-2940/91; A-2193)
530.102	r	(P-2940/91; A-2193)
530.103	r	(P-2940/91; A-2193)
530.104	r	(P-2940/91; A-2193)
530.105	r	(P-2940/91; A-2193)
530.106	r	(P-2940/91; A-2193)
530.107	r	(P-2940/91; A-2193)
530.108	r	(P-2940/91; A-2193)
530.109	r	(P-2940/91; A-2193)
530.110	n	(P-2940/91; A-2193)
530.111	r	(P-2940/91; A-2193)
530.112	r	(P-2940/91; A-2193)
530.113	r	(P-2940/91; A-2193)
530.114	r	(P-2940/91; A-2193)
530.115	r	(P-2940/91; A-2193)
530.116	r	(P-2940/91; A-2193)
530.117	r	(P-2940/91; A-2193)
530.118	r	(P-2940/91; A-2193)
530.119	r	(P-2940/91; A-2193)
530.120	n	(P-2940/91; A-2193)
530.120	r	(P-2940/91; A-2193)
530.121	r	(P-2940/91; A-2193)
530.122	r	(P-2940/91; A-2193)
530.123	r	(P-2940/91; A-2193)
530.140	n	(P-2940/91; A-2193)
530.150	n	(P-2940/91; A-2193)
530.200	n	(P-2940/91; A-2193)
530.201	r	(P-2940/91; A-2193)
530.202	r	(P-2940/91; A-2193)
530.203	r	(P-2940/91; A-2193)
530.210	n	(P-2940/91; A-2193)
530.220	n	(P-2940/91; A-2193)
530.225	n	(P-2940/91; A-2193)
530.230	n	(P-2940/91; A-2193)
530.240	n	(P-2940/91; A-2193)
530.250	n	(P-2940/91; A-2193)
530.260	n	(P-2940/91; A-2193)
530.270	n	(P-2940/91; A-2193)
530.275	n	(P-2940/91; A-2193)
530.290	n	(P-2940/91; A-2193)
530.300	n	(P-2940/91; A-2193)
530.301	r	(P-2940/91; A-2193)
530.302	r	(P-2940/91; A-2193)
530.303	r	(P-2940/91; A-2193)
530.310	n	(P-2940/91; A-2193)
530.320	n	(P-2940/91; A-2193)
530.330	n	(P-2940/91; A-2193)
530.400	n	(P-2940/91; A-2193)
530.401	r	(P-2940/91; A-2193)
530.402	r	(P-2940/91; A-2193)
530.403	r	(P-2940/91; A-2193)
530.410	n	(P-2940/91; A-2193)
530.420	n	(P-2940/91; A-2193)
530.430	n	(P-2940/91; A-2193)
530.440	n	(P-2940/91; A-2193)
530.450	n	(P-2940/91; A-2193)
530.460	n	(P-2940/91; A-2193)
530.470	n	(P-2940/91; A-2193)
530.480	n	(P-2940/91; A-2193)
530.500	n	(P-2940/91; A-2193)
530.501	r	(P-2940/91; A-2193)
530.502	r	(P-2940/91; A-2193)
530.503	r	(P-2940/91; A-2193)
530.510	n	(P-2940/91; A-2193)
530.520	n	(P-2940/91; A-2193)
530.530	n	(P-2940/91; A-2193)
530.600	n	(P-2940/91; A-2193)
530.601	r	(P-2940/91; A-2193)
530.602	r	(P-2940/91; A-2193)
530.603	r	(P-2940/91; A-2193)
530.610	n	(P-2940/91; A-2193)
530.700	n	(P-2940/91; A-2193)
530.701	r	(P-2940/91; A-2193)
530.702	r	(P-2940/91; A-2193)
530.710	n	(P-2940/91; A-2193)
530.800	n	(P-2940/91; A-2193)
530.801	r	(P-2940/91; A-2193)
530.802	r	(P-2940/91; A-2193)
530.803	r	(P-2940/91; A-2193)
530.804	r	(P-2940/91; A-2193)
530.810	n	(P-2940/91; A-2193)
530.820	n	(P-2940/91; A-2193)
530.830	n	(P-2940/91; A-2193)
530.840	n	(P-2940/91; A-2193)
530.900	n	(P-2940/91; A-2193)
530.901	r	(P-2940/91; A-2193)
530.902	r	(P-2940/91; A-2193)
530.903	r	(P-2940/91; A-2193)
530.904	r	(P-2940/91; A-2193)
530.905	r	(P-2940/91; A-2193)
530.906	r	(P-2940/91; A-2193)
530.907	r	(P-2940/91; A-2193)
530.908	r	(P-2940/91; A-2193)
530.909	r	(P-2940/91; A-2193)
530.11. A	n	(P-2940/91; A-2193)
708.70	am	(P-8193/91; A-194)
787.10	n	(P-13027/91; A-2882)
787.20	n	(P-13027/91; A-2882)
787.30	n	(P-13027/91; A-2882)
787.40	n	(P-13027/91; A-2882)
787.50	n	(P-13027/91; A-2882)
1030.11	am	(P-1271)
1030.30	am	(P-2449)
1030.84	am	(P-1271; A-2182; C-2957)
1070.20	am	(P-15428/91; A-2172)
1070.40	am	(P-15428/91; A-2172)
1311.10	n	(P-4195/91; W-2942)

TITLE 95

116.40	am	(P-558)
121.20	n	(P-561)

TITLE 95 (CONT'D)

121.30	n	(P-561)
121.40	n	(P-561)
121.50	n	(P-561)
121.60	n	(P-561)
121.70	n	(P-561)
121.80	n	(P-561)
121.90	n	(P-561)
121.100	n	(P-561)
121.110	n	(P-561)
121.120	n	(P-561)
121.130	n	(P-561)
121.140	n	(P-561)
121.150	n	(P-561)
121.160	n	(P-561)
121.170	n	(P-561)
121.180	n	(P-561)
121.190	n	(P-561)
121.200	n	(P-561)
121.210	n	(P-561)
121.220	n	(P-561)
121.230	n	(P-561)
122.10	n	(P-2113)
122.20	n	(P-2113)
122.30	n	(P-2113)
122.40	n	(P-2113)
122.50	n	(P-2113)
122.60	n	(P-2113)
122.70	n	(P-2113)